

**MINNESOTA STATE PLAN FOR DOWNSIZING  
LARGE INTERMEDIATE CARE FACILITIES FOR PERSONS  
WITH MENTAL RETARDATION OR RELATED CONDITIONS**

Minnesota Department of Human Services  
Division for Persons with Developmental Disabilities  
April, 1991



STATE OF MINNESOTA  
DEPARTMENT OF HUMAN SERVICES  
Human Services Building  
444 Lafayette Road St. Paul,  
Minnesota 55155-3815.

April 22, 1991

The Honorable Jerome H. Hughes  
President of the Senate  
Minnesota State Senate Room  
328, State Capitol Saint Paul,  
Minnesota 55155

The Honorable Robert Vanasek  
Speaker of the House Minnesota  
House of Representatives Room 463,  
State Office Building Saint Paul,  
Minnesota 55155

Dear Senator Hughes and Representative Vanasek:

Attached is the report to the Legislature required by Minnesota Statutes chapter 499, section 3 regarding a plan for downsizing large intermediate care facilities for persons with mental retardation and related conditions. You may recall that this statute was passed in the 1990 Legislature to require the commissioner of human services to develop a plan to stop discharges from regional treatment centers to larger community intermediate care facilities.

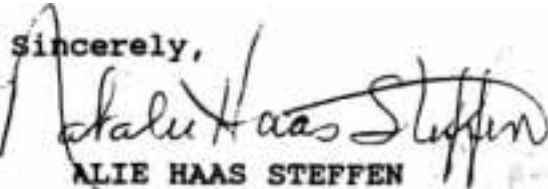
Implementation of the requirement to no longer place individuals from the regional treatment centers into large community facilities must go hand-in-hand with an orderly plan which accounts for the fiscal impact on these facilities, the development of smaller community-based homes, and assurances that the needs of affected individuals with developmental disabilities are adequately met. This report reviews various options to pursue and makes recommendations for specific legislative authorizations to downsize these larger facilities and establish smaller community homes for the individuals with



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The Honorable Jerome H. Hughes  
The Honorable Robert Vanasek  
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developmental disabilities currently served in them. I feel confident that as appropriations become available, this plan can provide a road-map for addressing the issues of large intermediate facilities. If there are questions, I will be happy to answer them or please call Shirley Schue, Division for Persons with Developmental Disabilities at 296-9139.

Sincerely,  
  
ALIE HAAS STEFFEN

NAT.  
Commissioner

Enclosure

cc: The Honorable Linda Berglin, Chair  
Senate Health and Human Services  
G-9 State Capitol

The Honorable Don Samuelson, Chair  
Senate Health and Human Services, Division of Finance  
124 State Office Building

The Honorable Alan W. Welle, Chair  
House Health and Human Services  
437 state Office Building

The Honorable Lee Greenfield, Chair  
House Health and Human Services, Division of Appropriations  
375 State Office Building

## EXECUTIVE SUMMARY

The 1990 Legislature in Chapter 499, Sect. 3 required that "The commissioner of human services, in consultation with representatives of intermediate care facilities, parents, advocates, and other interested persons and organizations, shall develop a plan to eliminate discharges from regional treatment centers to larger community intermediate care facilities."

The overall policy direction of the Legislature and the Department of Human Services in recent years has been to close and downsize large facilities and serve individuals with mental retardation only in small, community homes. Various initiatives move to shift services in this general policy direction.

Current statute Section 256B.092 Subd.7 requires that as of July 1, 1991, no individual who currently resides in a regional treatment center for persons with mental retardation and related conditions shall be discharged into an intermediate care facility for persons with mental retardation (ICF-MR) of more than 15 beds. Implementation of this requirement has a fiscal impact on these facilities, a programmatic impact on individuals with mental retardation currently residing in them, and an effect on the community service options for residents of regional treatment centers. Hence, implementation of the 15-bed limitation must go hand-in-hand with an orderly plan and sufficient resources to provide for the needs of the individuals currently served in such facilities. If the Legislature does not fund the resources for smaller community alternatives for the people involved, the implementation of the 15-bed requirement should be postponed until such time as an orderly plan can be implemented.

Full implementation of the "15-bed" limitation would require a significantly large commitment of resources to develop small community alternatives for the individuals served. However, regardless of the 15-bed limitation, many facilities have closed in recent years. Closures will be occurring whether the 15-bed limitation is implemented or not, so the numerous pressures and demands on these facilities require that at least some immediate, painful actions be taken toward downsizing.

## RECOMMENDATIONS

1. Continue use of voluntary closure of these facilities under Minnesota Statute Section 252.092.
2. Develop alternative services for residents in and close all class A facilities over 20 beds and the class B facilities that have aging physical plants.
3. Allow exceptions to the 15-bed limit for individual placements from the regional treatment centers into larger Class B facilities. Exceptions would be allowed based on individual preference, the facility capacity to serve the individual, and the county case management process.
4. Implement a demonstration project in the next two-three years to document information needed before a more wide-scale downsizing plan is implemented. This demonstration project would determine the costs and programmatic feasibility for downsizing larger class B facilities and for development of more creative options for community-based alternative services.

DEPARTMENT OF HUMAN SERVICES PLAN  
FOR DOWN-SIZING LARGE ICF-MR FACILITIES

This plan is submitted in response to the following requirement:

Chap. 499, Sec. 3 (PLAN FOR DOWNSIZING INTERMEDIATE CARE FACILITIES)

The commissioner of human services, in consultation with representatives of intermediate care facilities, parents, advocates, and other interested persons and organizations, shall develop a plan to eliminate discharges from regional treatment centers to larger community intermediate care facilities.

I. HISTORY OF LEGISLATIVE INITIATIVES

Services to Minnesota citizens with developmental disabilities have rapidly changed in the last twenty years, and continue to do so. The shift from larger institutions and buildings to smaller, more individualized, community-based services reflects national trends, and Minnesota has been a leader in those trends. The 1990-91 State Plan identified the values on which services to individuals with developmental disabilities are based, and the values which new service designs strive to implement. These values include:

- Persons with developmental disabilities should live, work, and participate in leisure activities in age-appropriate, culturally typical and least restrictive environments.
- All programs and services for persons with developmental disabilities should promote independence, productivity, community integration, and opportunity, in safe, healthful environments.

Numerous initiatives over the last few years have served to make these values a reality, in various areas: supporting children in remaining at home with their families, in creating supported and integrated living and work arrangements, and in community leisure activities. In the critical area of residential support services, the state has made remarkable progress in implementing a wide variety of small, community homes. These initiatives include:

- a. A decrease in the regional treatment center population from 2371 in 1982 to approximately 1250 people currently.
- b. Implementation of the Title XIX (Medicaid) home and community-based waiver, which is now used to serve approximately 2350 total people in adult foster homes and small supervised group living arrangements, and children supported to remain at home with their families.
- c. Passage by the Legislature in 1983 of the authorizing legislation for the Medicaid waiver and establishing a moratorium on ICF-MR beds. Under this moratorium, certain exceptions were allowed; one of the major criteria for any new ICF-MR construction is that new facilities are limited to 6 beds or less.
- d. In semi-independent living services, an increase from 458 people in 1979 to 1350 people currently.
- e. In adult foster homes, an increase from 411 people in 1979 to approximately 1850 people currently.

f. Significant strides in supporting children in remaining at home with their families. In 1980, 50 children received in-home services and 830 children received 24-hour out-of-home care; in 1990, 1827 children received in-home services and only 291 children received 24-hour out-of-home care.

g. A ten-year plan for decreasing the majority of the regional treatment center population, and relocating current residents to small state and privately operated community homes.

h. Passage by the Legislature in 1987 for the Community Conversion project (Section 252.292), which allowed the Department to enter into plans with community ICF-MR facilities to close and move their residents to smaller community homes.

h. Downsizing of a number of small facilities, as they converted from "class A" to "class B" facilities (which included rate adjustment increases for more intensive programs and life safety code modifications).

An example of the programmatic and fiscal impact of support for smaller, more homelike settings is the family support program for children with developmental disabilities. In 1980, \$20.4 million was spent to support 830 children in 24-hour out-of-home care, while only 50 children were supported to remain at home with their families, with an expenditure of \$150,000. By 1990, 291 children were served in out-of-home care at a cost of \$10.8 million, and 1827 children received in-home support at a cost of \$13.4 million. Thus, in 1980 880 children were served at a total cost of \$20.4 million. By 1990, with more support for in-home care, a total of 2118 children were served at a total cost of \$24.2 million.

In addition, recent years have seen several proposed legislative bills regarding the down-sizing of large intermediate care facilities. Although none of these proposals have been passed, the intention of them has matched the general overall policy direction toward the closure of large facilities and movement of individuals into small community homes.

## II. COMMUNITY-BASED INTERMEDIATE CARE FACILITIES (ICFs-MR)

A notable feature of the developmental disabilities services system in Minnesota is community-based Intermediate Care Facilities (ICFs-MR). Minnesota was one of the earliest users of this federal program, and continues to be one of its most significant users. Currently, there are 317 community ICF-MR facilities licensed under Rule 34, with over 4000 residents. Approximately 37% of those persons, or 1550 people, reside in facilities with 15 or more beds.

In recent years, the Department of Human Services has closely examined the quality of care in these facilities and has worked with counties and providers who voluntarily chose to close, downsize, and/or re-license their facilities as smaller community living residences. The net reduction in both regional treatment center and community ICF-MR beds in the last ten years is shown in the following table.

## NUMBER OF CERTIFIED ICF/MR BEDS IN MINNESOTA

	Total ICFs/MR	Regional Treatment Centers (ICFs/MR)	Community ICFs/MR
1980	7196	3079	4117
1981	7345 (+160)	2849 (-230)	4507 (+390)
1982	7338 (-18)	2679 (-170)	4659 (+152)
1983	7559 (+221)	2617 (-62)	4942 (+283)
1984	7516 (-43)	2394 (-222)	5121 (+179)
1985	7518 (+2)	2315 (-80)	5203 (+82)
1986	7526 (+8)	2315 (-0)	5211 (+8)
1987	7022 (-504)	1950 (-365)	5072 (-139)
1988	6701 (-321)	1915 (-35)	4786 (-286)
1989	6395 (-306)	1894 (-21)	4501 (-285)
1990	6070 (-325)	1650 (-244)	4420 (-81)

Source: Survey and Compliance Section,  
Department of Health

Since the fall of 1985, more than thirty community ICFs-MR have closed, 12 of which had more than 15 beds. These facilities ranged in size from 6 to 165 beds and included the largest community Intermediate Care Facility in the state. Many closed as a result of formal closure agreements with DHS. In addition, a number of other facilities have closed some beds. Facilities have closed for various reasons: significant health and safety risks, financial difficulties, and the Department placing some facilities in receivership. As indicated in the above table, up to March 1990, approximately 800 net community ICF-MR beds had been decertified and a comparable number of persons relocated to other settings. As of April 1991, another 100 beds have either been decertified or represent facilities with agreements to close over the next year. (A list of the community ICF-MR facilities which have closed and which have closure agreements is contained in Appendix A.)

In the last ten years, the average monthly population in the regional treatment centers has decreased from 2,632 in 1980 to 1,213 in 1991. The above table shows that since 1986, efforts to close community ICF-MR beds have been as aggressive as efforts to close regional treatment center beds. From 1986 through March of 1990, 665 regional treatment center beds and 791 community ICF-MR beds were closed. (See updated information regarding closed and closing community ICF-MR facilities in Appendix A.)

The demand for community residences continues to increase, especially for small community homes. (Because of the ICF-MR moratorium, the Department has denied a number of need determination requests in the last five years.) To respond to this demand, the 1988 legislature approved the development of 150 beds for new, small community-based ICFs-MR during the 1990-91 biennium. The Department has worked with private providers and counties to establish these facilities in those areas of the state where the need is greatest. These facilities are limited to six beds, with some 4 and 5 bed facilities allowed.

To date, 17 facilities, serving a total of 90 people, are either open or are scheduled to open shortly.

Working with representative counties, providers, and consumer organizations, the Department has developed a ten-year plan to move most of the current regional treatment center population to small community homes, operated by both private providers and by the State (State-Operated Community Services). This plan was passed by the 1989 legislature. A separate requirement that went hand-in-hand with this plan and the overall statewide trend toward smaller community-based homes was also passed by the 1989 legislature. This requirement was that as of July 1989, no resident of a regional treatment center could be admitted to a facility of more than 15 beds. This legislation was in effect for one year, and then implementation was suspended until July 1, 1991. Since implementation was suspended on July 1, 1990, at least six persons have been moved from regional treatment centers into intermediate care facilities of more than 15 beds, thus far this fiscal year. Current legislation requires that as of July 1, 1991 no regional treatment center residents can be admitted to a facility of more than 15 beds, and by 1993 to a facility of more than 10 beds. Implementation of this requirement affects all community intermediate care facilities which have more than 15 beds, and in 1993 those with more than 10 beds.

When the prohibition on placement from the regional treatment centers was in effect from July 1, 1989 to July 1, 1990, several problems were experienced and would continue as problems with the implementation of the 15-bed limit. First, many individuals, especially in the larger Class A facilities, could move to smaller homes in the community using the Medicaid waiver or other options. However, the waiver requires that if an individual moves to a waiver-funded alternative, an ICF-MR bed must be decertified. Since state reimbursement is based on a daily rate for the number of occupied beds, the facility often faces lost revenue in those cases of a decertified or unoccupied bed.

When an ICF-MR bed is vacated, it cannot be filled by an individual currently served by the waiver in the community (unless the individual was no longer funded by the waiver), nor could it be filled from the regional treatment center if the 15-bed requirement were in effect. With the 15-bed limit, a bed made vacant through death or a person moving to a non-waiver funded community alternative could only be filled by a person currently living in the community with non-waiver funding. However, many parents do not want their son or daughter to move from home into a large facility, and some do not want their child to move from the regional treatment center into a large facility. In addition, many of the individuals who are eligible to move into the facility are more difficult to serve than the individuals the facility is used to serving or is able to serve at their current per diem reimbursement level on a long-term basis. (Short-term funding is available via Rule 186, but the placement needs to be long term.) These systemic and funding factors contribute to a tendency on the part of some providers and case managers to "hold" current residents in order to maintain their ICF-MR population. With no admissions from regional treatment centers and limitations on placement in large facilities for individuals currently living in the community, implementation of the 15-bed limitation in July 1991 may result in serious fiscal difficulties for many of these facilities.



### A. Current Status of Community ICFs-MR

Of the 317 licensed ICF-MR facilities In Minnesota, there are currently 41 which are licensed by Rule 34 for over 15 beds, and 98 which are licensed for 11 to 15 beds. (A list of the facilities over 15 beds by region is attached in Appendix B). Approximately 1500 people live in the facilities over 15 beds, 1400 in the facilities between 11 and 15 beds, and 1200 in the facilities between 4 and 10 beds.

Intermediate care facilities are licensed as either "class A" or "class B" facilities. Residents of class A facilities have been determined by the Department of Health to have the capacity to self-preserve, to exit the building under their own capacity in an emergency such as a fire. Residents of class B facilities typically do not have this capacity, and are typically more severely handicapped and/or physically impaired. Within the "class B license, there are two categories: "Institutional B" refers to facilities, regardless of size, which are accessible and meet the "institutional" life safety standards. "Residential B" homes are for individuals who cannot self-preserve but do not necessarily need accessible housing; the homes are not accessible and meet the "residential" life safety standards. They are always 16 beds or under.

Of the 41 facilities over 15 beds, 12 are class A facilities. Three have more than 100 beds and nine have between 16 and 60 beds. There are a total of 29 class B facilities with over 15 beds. Eleven have between 43 and 64 beds, and 18 have between 16 and 35 beds. Of the 26 A and B facilities between 16 and 35 beds, 10 have 16 beds. (See charts in Appendix B.)

Each ICF-MR facility, no matter which of the three license types it holds, almost always has a mix of level of disabilities. That is, class A homes may have some individuals who are very severely impaired, and class B homes may have some individuals who are more mildly handicapped. Almost every facility, except some of the larger Class A facilities, has at least some individuals with significant impairments. Most of the more mildly handicapped individuals are in Class A facilities, although there are some persons with mild disabilities in many of the Class B facilities.

The charts in Appendix B describe the level of care of residents in all the facilities licensed over 15 beds. These levels of care were determined in the Quality Assurance Reviews by the Department of Health. In general, the class B ICF-MR facilities are used for persons with more significant levels of impairment; of all facilities, a total of 85X are in the moderate to maximum ranges of levels of care. The striking exception are the three largest facilities, all licensed as class A and all having more than 100 beds. A total of 46X, or almost half of these residents, have been classified in the two mildest ranges of levels of care.

## B. Issues Currently Facing Facilities

Many of the large intermediate care facilities already face numerous problems. As indicated above, many have voluntarily chosen to close in recent years. These closures and some downsizing are often in response to crises, or happen inadvertently. This pattern of closures will in the long run be more risky and costly than if planned efforts are undertaken. It is important to be deliberate and direct in planning, to maximize the best outcomes for individuals in the most cost-effective manner. These outcomes are more likely to occur if crisis responses are replaced with proactive, planned, deliberate action.

Many facility problems have been exacerbated by the 15-bed limitation on placements from the regional treatment centers. Some of these problems and issues include:

### 1. Safety and Aging Buildings

Several of these facilities are aging buildings, or are overcrowded. Although continuing to invest in additional renovations makes sense for some facilities, there are some for which major investment in capital expenditures would be unwise. Most are also close to being fully depreciated.

A second issue is that several larger class B facilities were originally built as children's facilities and were designed to house children with severe mobility impairments. Many children have grown up in these facilities and are now adults. At least some of their families would prefer they stay in the facility in which they are comfortable and in which they have grown up. However, the children are now young adults who have outgrown the facilities and their accommodations (bathrooms, etc.). These residents either need to move to a different facility or, if they remain in the current facility, physical features of the building may need to be modified to safely and appropriately accommodate them.

### 2. Privacy/Program Effectiveness

Several programmatic factors, including overcrowding, affect the number of people that should be in each bedroom. Many individuals with serious behavior difficulties may need to be in their own room, especially in consideration of the vulnerability of other residents; many individuals with these behavior difficulties have decreased their negative behaviors when they have their own rooms. Space considerations also affect how many individuals with complex medical equipment should be in the same bedroom. Increased active treatment demands by the federal government, habilitation requirements, size of household, and quality of life issues also affect the degree of privacy needed by most ICF-MR residents. These considerations have been incorporated into the plans for the development of the new state-operated community services (SOCS) homes and many of the new private sector homes.

### 3. Severity of Handicap

As smaller community homes have developed in the last 15-20 years, most of the individuals who left both the regional treatment centers and the larger intermediate care facilities were more independent and mobile. More recent admissions to the large intermediate care facilities from the regional treat-

ment centers and from the community have been individuals with more severe physical impairments, deficits in adaptive behavior, and more severe behavior problems. It is likely that the cost of developing and operating smaller, more individualized community homes for these individuals may initially be higher than the development of previous community alternatives; however, these individuals tend to be more expensive to serve no matter where they live.

#### 4. Children

There is a large demand for residential capacity and for new options and services for all people, including children. Ideally, all children should have the opportunity to grow and develop in a family setting. If they do not have that opportunity within their natural family, for whatever reason, ideally another family setting should be available. The system in recent years has developed many new structures to support children in remaining at home with their own families or to live in other family settings; these new structures include family support and family subsidies, school programs for all children, and TEFRA.

As these other options have been developed, the need for out-of-home ICF-MR care for children has diminished. The regional treatment centers are no longer licensed to serve children, and many of the original children's ICF-MR facilities have changed to adult facilities as these children have grown up and remained in the same facility. Although all these trends have supported the best types of care, there is a small but persistent number of children who remain problematic. These are the children with quite severe and complex needs who are extremely difficult to serve in their own home or in a foster home. This number includes both young children with complex medical needs and a growing number of adolescents with severe behavior problems. Given the diminished capacity to serve children in ICF-MR programs, it has been difficult to locate the best and most cost-effective community living situations for them.

#### 5. Need for Crisis and Short-Term Intervention Capacity

Many families who are serving their children at home experience the need for support in crises, and for temporary stays out of the home. Some of the types of crises these families experience with their children include extreme behavioral incidents and severe medical crises. From time to time, a small community program may also experience the need to have a resident move elsewhere for a short period of time or to have more intensive treatment in a different setting. Currently the only alternative for this type of crisis intervention is short-term placement in a regional treatment center, where it is impossible to provide the effective, community-oriented behavioral interventions required for successful re-entry to the community. Frequently the lack of crisis intervention results in the permanent placement of individuals in more expensive settings. Plans for alternative community services for the current ICF-MR population must include adequate development of crisis intervention and short-term care services.

#### 6. The ICF-MR role for the future

Many community ICF-MRs have closed in recent years, including very large ones. The role of the remaining facilities, especially the larger Class B facilities, has evolved in recent years. As individuals who needed less care have

moved elsewhere, these facilities have come to serve a far more dependent and disabled population. Because studies and experience in Minnesota and elsewhere have documented both the dramatic progress of people in home-like settings and the cost-effectiveness of such alternatives, the overall thrust for the future is toward small, community homes for all individuals, even those with the most severe disabilities.

As the total number of ICF/MR beds is being reduced, tightly structured exemptions to the ICF/MR moratorium would continue to allow the state and counties to meet the needs of those persons with severe handicaps, as recommended in the January 1988 Department report on the assessment of the impact of the ICF/MR moratorium. Development of small ICF/MR programs should be considered after a county has fully utilized their waiver allocations, changed their existing ICF/MR capacities to the extent possible, and fully utilized semi-independent living services, family subsidies, personal care, and other generic social and medical services.

In the meantime, there may be limited options for the larger community ICF/MR facilities and/or the need to define a specific, interim role for the larger facilities which are accessible and can serve the more dependent and disabled population. In the near future, this interim role may be necessary as more small, individualized homes are realized for a gradually increasing number of people. For the far future, the entire system continues to face the challenge of developing more feasible and preferred, smaller alternatives without expending a great deal more funds than the system would have otherwise cost.

### III. PROCESS TO DEVELOP THIS PLAN

As a result of the limitation on placements from regional treatment centers into large ICFs-MR, the Department was required by the Legislature to develop a plan for the downsizing of these facilities. Implementation of this "15-bed rule" must go hand-in-hand with an orderly plan to account for the fiscal impact on these large community facilities, the development of smaller community-based homes, and assurances that the needs of affected individuals with developmental disabilities are appropriately met.

#### A. Advisory Committee

In accordance with the legislation requiring the development of this Department plan, an advisory committee was formed to consult with the Department. This committee consisted of four executive directors of affected facilities, a director of a facility which had closed, three consumer/parent representatives, one county social services representative, a representative from the Department of Finance, and representatives from the Association of Residential Resources of Minnesota, a state-wide organization representing the majority of affected facilities. A list of members is contained in Appendix C. Although this committee did not always agree, they did provide a wide variety of valuable input to the Department in the generation of this plan.

This committee analyzed and discussed the relevant requirements affecting downsizing and closure, and defined the current issues facing large facilities. The Department and committee also generated various different alternative scenarios for downsizing and closure of facilities. To determine which avenue would most merit recommendation, the committee generated criteria to be used to evaluate the worthiness of any particular plan or avenue.

## B. Where Are We Going? (Long-Range Service System Goals)

The committee looked at overall principles and long-range goals for the service system, and visions and goals for services for the next decade. What is planned now regarding down-sizing should fit into appropriate long-range goals for the entire service system. If only short-sighted, immediate steps are taken, those steps could result in limited and less desirable change, and change which is more costly in some cases – which will only require additional cycles of change and far more expense at a later date. If the service alternatives pursued now for the residents of downsized facilities are not centered around the values of state policy and do not support individually-designed homes, it is likely Minnesota will end up with even more buildings in 10-20 years that are unwanted and do not meet the needs of the people required to live in them. Many younger parents of children with developmental disabilities are already adamant in their views about accepting only small, individualized community homes. They are ardently rejecting the concept of "facilities" when placement of their children is proposed.

The advisory committee expressed the following principles as long-range goals for this plan and its relationship to how the overall service system should be designed, as reflected in the State Plan:

### 1. Individuals should live in homes that are as a typical as possible.

Individuals with developmental disabilities should live in homes not facilities. These homes should be as similar to those of other citizens as possible and include as wide a variety of environments and residences, such as single-family houses, duplexes, town houses, apartments, farms, and people owning their own homes. Also, the supports and services which individuals need should be provided. Children should live in families and with other children, and natural families should also be supported in caring for their children with disabilities.

### 2. Living situations should be based on informed choice and individual planning.

The individual's preferences and their family's preferences should be the basis for deciding where the individual should live. Unfortunately, individuals with disabilities, their families, and the service system have become accustomed to making choices only based on the traditional or available options; people have been trained to "prefer" what they can get. The basis for decisions on placement must be informed choice that goes beyond information about only currently available options, but also includes development of options not yet available, and the expression of wants, desires, and preferences by the individual with disabilities and their family as freely as any citizen expresses those. Individuals should not be over-served, or served through means or programs that do not fit what is really needed. Meaningful, preferred homes and services that are designed around what individuals really need are the most cost-effective in the long run.

3. New, flexible living arrangements should be available, and should be based on money following people rather than facilities

There should be flexibility both in the funding stream and in regulations to support a wide variety of individual supports and housing options. New, more creative arrangements which could be utilized include consumer-owned housing, individuals living in their own homes and renting out rooms, shared rentals, and easier access to personal care attendants.

Alternative system designs should be promoted that will allow individuals and/or their guardians more flexibility in using money, with more individual control of the type of home developed and services used. The Medicaid waiver is a good example of funding which is tied to the individual and offers some degree of flexibility in implementation of living arrangements. However, many other program funds, including ICF-MR monies, are tied to beds or facilities, forcing individuals to choose between limited options of where beds are available.

These three overall goals for the future, long-range design of the service system were tied to development of criteria for evaluating different plans to down-size large community intermediate care facilities.

#### IV. CRITERIA FOR EVALUATION OF DIFFERENT PLANS

The advisory committee and DHS staff, in considering the many different issues involved in down-sizing, agreed on five criteria to consider in the evaluation of any down-sizing plan. These criteria reflect differing issues which should be weighed in determining the relative merits of any proposed action.

These five criteria are as follows:

##### 1. Extent to which the option matches overall policy direction

Any action which is taken should match previously stated intentions of the Department and the Legislature. As expressed in the 1990-91 state plan, the overall intention and direction for services for persons with developmental disabilities is that individuals should live in as small, culturally typical and individualized settings as possible. The Legislature's requirement that individuals from the regional treatment centers should not be placed in facilities with more than 15 beds, and the limitation on new community ICFs-MR to 6 beds, both reflect this overall commitment to smaller living situations. This overall policy direction is also reflected in the three long-range goals for the service system generated by the Advisory Committee and described in the previous section.

##### 2. Extent to which the option demonstrates respect for individual needs and allows implementation of individual choice

Individual needs must be respected in any downsizing or closure considerations, especially vulnerability and the more complex needs of an increasing number of individuals in the ICF-MR system. Consumer, family, and guardian concerns must also be respected. Alternative services that are developed should be real and creative, reflecting more flexibility and individuality than traditional models of care.

##### 3. Extent to which the option addresses safety, privacy, and other programmatic issues

Safety and physical space issues in any given facility should be taken into account in considering down-sizing or closure. The issue of physical plants which were originally built for children but which now house adults must be addressed. In addition, the number of individuals to be accommodated in a bedroom must be planned in a way which addresses privacy and safety needs, resident choice, quality of life, and effective treatment and programming.

##### 4. Extent to which the option appropriately redesigns overall community capacity

Any plans which affect the future capacity of the system, including ICF-MR space, must take into account the individuals who would be displaced, who are currently unserved or are on waiting lists, and the needs of families who are currently caring for their children at home. These populations include children with high behavioral and/or medical needs, and the many individuals with high needs who will need crisis intervention and short-term service alternatives. Given the continuing need and demand for smaller residential services, this is a critical issue.

## 5. Cost of each option

Consideration of any option must include consideration of all of the expenses involved. At a minimum, these costs include:

- interim rates for existing facilities while closing or downsizing
- costs to upgrade existing physical plants
- administrative costs to Department of Human Services and Department of Health (e.g., auditing, licensing and certification, etc.)
- development of alternative community services, including new ICF-MR, waiver, and other alternative services

There are also long-range cost implications. For instance, it is more cost-effective to downsize a facility only once. If a facility were downsized 20%, then another 20%, the costs would be much higher than if it were downsized just once at 40%. The more times a facility is downsized, the more fiscally unfeasible the actions become. Although it may appear to cost less to downsize a minimal amount in the near future, that action should not be taken if another cycle of downsizing is going to occur in the next biennium: the total costs will be greater than simply taking the desired step just once. Long-range planning and consideration of long-range effects is required.

Other long-range cost implications include the costs of continuing to fund the facilities as they are (i.e., the cost of doing nothing), and the ultimate negative effects if decisions are based solely on facility costs rather than the above-mentioned principles regarding individual need, respect for individual choice, and programmatic issues.



## V. DOWN-SIZING PLAN OPTIONS

Given the issues facing ICF-MR facilities and the trends in service system design, there are multiple possible alternatives which could be generated for a down sizing plan. From all of the possible options, the Advisory Committee generated the following four scenarios for the downsizing of large community ICFs-MR. These scenarios were generated to help study all the issues involved, and range in aggressiveness of approach; these scenarios are not intended to foreclose on other options. In brief, these four scenarios are:

SCENARIO I. Downsizing and/or closing all community ICFs-MR, to no more than 15 beds and no more than 10 beds by 1993.

SCENARIO II. Downsizing and/or closing all community ICFs-MR to no more than 15 beds.

SCENARIO III. Closing all class A facilities over 16 beds. Allowing a limited downsizing (up to 25%) of Class B facilities more than 15 beds for reasons of safety, overcrowding and privacy, and use of some space for crisis intervention and short-term stays. Scenario III is similar in some respects to the 1989 proposed downsizing legislation, reducing facilities with 24 or fewer beds to 15, and for facilities between 25 and 100 beds requiring a 25% reduction in beds.

SCENARIO IV. Allowing all facilities to move to the waiver any individual who can be served within the waiver average closing beds and adjusting the rates of each facility as these planned moves occur.

Each scenario is laid out in the following table. Table A explains each scenario in more detail, and lists the number of facilities and number of people affected in each scenario.

### Match of Each Scenario to Evaluation Criteria

To evaluate the relative merit of each scenario, it is important to consider each against the five evaluative criteria. The following chart shows the degree of match between each of the four scenarios with the five evaluation criteria, in relationship to each other. These degrees of match are as follows:

	<u>Policy Direction</u>	<u>Individual Choice</u>	<u>Program Issues</u>	<u>Overall Capacity</u>	<u>Cost</u>
Scen. I	Very High	Mixed	Very High	Mixed	Very High
Scen. II	High	Mixed	High	Mixed	High
Scen. III	Medium	Mixed	Medium	Mixed	Medium
Scen. IV	Low	Mixed	Medium	Mixed	Medium

TABLE A DOWN-SIZING SCENARIOS  
NUMBER OF PEOPLE NEEDING ALTERNATIVE SERVICES UNDER EACH SCENARIO

City:	<u>Large 25+ Beds</u>		<u>Intermediate 16-25 Beds</u>		<u>11-15 Bed Facilities</u>		TOTAL PEOPLE
ss:	<u>A</u>	<u>B</u>	<u>A</u>	<u>B</u>	<u>A</u>	<u>B</u>	
	7 facilities	16 facilities	5 facilities	13 facilities			
SCENARIO:							
I.	Close	Close	Close	Close	reduce to 10	reduce to 10	
	465 people	747 people	100 people	233 people	297 people		1842
J.	Close	Close	Close 20+ Beds Downsize 16 to 15 or less	Reduce to 15	-----		
	465 people	747 people	70 people	38 people			1320
K.	Close	Limited Downsize (25%)	Close 20+ Beds Downsize 16 to 15 or less	Reduce to 15	-----		
	465 people	187 people	70 people	38 people			760
L.	Downsize through Waiver & Rate Adjustments		Downsize through Waiver & Rate Adjustments		-----		
	116 people	187 people	25 people	58 people			386

A more detailed explanation of the issues related to each of the five criteria in each of the four scenarios, the merits and limitations of each scenario, are more fully explained in Appendix D.

### Costs

In brief, the estimated costs of each of the four scenarios is as follows.

#### TOTAL COST (in millions)

	<u>SCEN. I</u>	<u>SCEN. II</u>	<u>SCEN. III</u>	<u>SCEN. IV</u>
FY 92	.35	.25	.14	.37
FY 93	4.7	3.1	2.0	.78
FY 94	18.8	12.2	7.9	3.3
FY 95	34.7	22.4	14.6	6.2
FY 96	52.7	34.0	22.2	9.5

#### STATE SHARE (in millions)

	<u>SCEN. I</u>	<u>SCEN. II</u>	<u>SCEN. III</u>	<u>SCEN. IV</u>
FY 92	.35	.25	.14	.37
FY 93	3.0	2.0	1.2	.52
FY 94	10.7	7.1	4.4	2.1
FY 95	18.9	12.4	7.8	3.9
FY 96	28.3	18.6	11.7	6.0

More specific cost explanations, and the cost assumptions used in developing these estimates, are contained in Appendix E.

## VI. RECOMMENDATIONS

In comparing the cost of each scenario with the number of people that will be served (Table 1), it is evident that on a cost-by-individual case basis, it is less expensive in the long run to close facilities than to downsize them. (For example, the average per-person cost in 1996 in Scenario I, which closes all facilities over 15 beds is \$15,364. In contrast, in Scenario IV no facilities are closed and the average per-person cost in 1996 is \$15,579. Although Scenario IV is the least amount of total funds and the smallest number of people are impacted, the per-person cost is the highest. In the long run, this alternative would be the most costly.)

However, at this time, massive closings would require a large amount of state resources. If large resources were not immediately committed to such closings, interim actions are necessary for the short run.

Balancing the merits and difficulties of each of the above four scenarios, the Department recommends implementation of scenario III, with some additions and modifications. The following recommendations were generated respecting the continuing need and demand by individuals, their families, and counties for smaller residential homes. Given that closures will happen, for a variety of reasons, the Department needs to do additional planning beyond responding to voluntary closure requests and emergency or crisis situations.

The following four recommendations and the recommendation for Scenario III take into account full consideration of each scenario against each criteria for evaluation, total cost, and degree of movement toward the long-range principles for the services system. The essential elements of the plan continue to move the overall system away from larger settings, and will enable more individuals to live in homelike environments. These recommendations balance implementation of the general policy direction of the Department and Legislature with total cost, and form a reasonable plan to move services toward desired outcomes in a manner that balances both individual need and current system realities. They represent significant strides toward implementation of desired outcomes, but in a manner that allows good planning based on individual needs and system capacity.

### 1. CONTINUE USE OF VOLUNTARY CLOSURE

Several facilities have indicated a desire to voluntarily close. The Department should continue to work with these facilities and counties to develop alternative community services for the residents of these facilities and to close them, as appropriations are made available for this purpose.

### 2. DEVELOP COMMUNITY ALTERNATIVES AND CLOSE THE LARGER A FACILITIES AND AGING CLASS B FACILITIES

The largest class A facilities (over 20 beds) should be closed. Many of the current residents of these facilities can be served by the Medicaid waiver, and the remaining could be served in new small ICFs-MR. Implementation of the 15-bed requirement and these closings should take place concurrent with the development of these new community alternatives, and a Legislatively approved plan and resources for the development of these services. The provider of the existing facility should also be given the opportunity to respond to requests for proposals to develop the new services.

If the ten largest class A facilities were closed (all the homes over 16 beds), new small community homes would have to be developed for approximately 535 people. We recommend the Department enter into closure agreements with these facilities and that all be closed within the next five years (1996). Certainly a reachable, less aggressive but yet reasonable goal is to close at least the three largest class A facilities (309 people) by 1996.

Estimated costs to close the three largest class A facilities:

	TOTAL COST	STATE SHARE (in millions)
1992	.32	.32
1993	.49	.33
1994	2.1	1.3
1995	3.8	2.3
1996	5.8	3.5

In addition, some class B facilities have very poor, aging physical plants, such as Lake Owasso, which will need to be replaced in any case. Facilities with deteriorating physical plants should be closed and replaced with small community homes, instead of recapitalizing these large facilities. In replacing these old buildings with new small community homes, the majority of the investment would be in program operating and administrative costs, rather than buildings. It is projected that after the dispersion of Lake Owasso residents into small community sites is completed, there would be an additional \$700,000 a year in state costs.

3. MODIFY IMPLEMENTATION OF THE 15-BED LIMIT

The 15-bed limit on placements from the regional treatments centers is programmatically valuable and in full accordance with Department and Legislative policy direction toward small, community homes. However, full implementation would require a great degree of capacity building and change for individuals, families, and programs. In addition, implementation of the requirement without the accompanying resources to development community alternatives would be damaging to both the individuals served and the facilities. Recognizing the lack of accessible housing and often limited options for the most difficult individuals, we recommend that exceptions to the 15-bed limit be made on a case-by-case basis for individual placements in class B facilities on the basis of individual preference for that residential placement, the facility's capacity to serve that individual, and utilizing the county case management process.

4. IMPLEMENT A DEMONSTRATION PROJECT

Plans for the future are based on several critical factors, some of which should be demonstrated and documented. As these recommendations are implemented, a demonstration project would allow study of these several critical factors that are important in realizing a system based on more individualized, small community homes. This demonstration project would include the following two components:

a. Demonstrate the feasibility of downsizing the largest class B facilities

Many of the largest class B facilities are currently serving very difficult people. Although some of these individuals can be moved to smaller homes using the waiver and other ICF-MR funds, at this point in time it would be much more expensive to serve this entire group of people in smaller settings. No class B facility has been significantly downsized without closing, so the fiscal and programmatic impacts need to be determined.

These homes should be downsized at a fiscally and programmatically reasonable level (perhaps 25%), or as long as they can stay within the limitations in Rule 53. This downsizing would allow some facilities to develop crisis intervention and short term services, and to modify current space to impact programmatic effectiveness. Such modifications to use some beds for these new services would also require certain changes in funding rules.

For the demonstration project, we recommend that at a minimum two class B facilities be selected to downsize. These two facilities should be selected on the basis of safety, overcrowding and other programmatic issues, and their capacity to offer crisis intervention and short-term stay services. The demonstration project would provide the opportunity to determine the rule changes and fiscally feasible methods which need to be developed to allow the cost-effective utilization of these facilities for these purposes.

It is estimated that to downsize two Class B facilities 25% for a total of 100 beds would cost the state \$630,000 annually for additional alternative services and rate adjustments.

b. Demonstrate feasibility of developing new alternatives and initiatives

Smaller community-based residential services within Minnesota have tended to rely almost exclusively on ICF-MR and Medicaid waiver funding. However, there are many other alternatives for services which have been successfully implemented in other states and in individualized cases within Minnesota, including vouchers, client-owned housing, and other options discussed above. We recommend that these options be encouraged and developed. As they are developing, various features of feasibility, cost-effectiveness, regulation, monitoring, and overall programmatic integrity need to be explored. Providers, counties, and the state need avenues to gain experience with these options before pursuing them on a more aggressive and wider scale. The costs, requirements, and programmatic methods to develop the new initiatives and alternatives would be studied within this demonstration project and provide sound experience for further expansion and/or modification of these options.

Part of the demonstration project could also include start-up monies to start experimental services. In addition, outside resources such as the University of Minnesota could be involved in the study of the various factors being explored in the demonstration project.

The Department would be open to developing a variety of alternative services and to use the state share of funding in creative manners. Responses to requests for proposals for services would be reviewed by members of the Commissioner's Task Force. It is estimated that the costs for this project would

be \$100,000 for the biennium. This amount would include \$25,000 in start-up grants to individuals or providers, and \$25,000 to study and assess the costs and feasibility of these alternatives.

## APPENDIX A

COMMUNITY ICF-MR  
FACILITIES CLOSED IN LAST 5 YEARS  
AND SCHEDULED TO CLOSE



## CLOSED AND CLOSING ICFs/MR

FACILITY	DATE	BEDS	REDEVELOPED
Project Independence	11-1-85	8	No
Bronstein Home	3-5-86	10	No
Aneskarn-Rosslaer	4-14-86	28	No
Lakeview	8-1-86	7	No
Lake Park Wild Rice	10/31/87 ✓	55	No
Alice Haney	6-30-87 ✓	40	No
Champions	12-18-87 ✓	16	No
Hilltop	10-29-87	10	No
Madden-Haven	7-1-87	45	No
St. Elizabeth	8-1-87	14	No
Woodvale-Kassen	9-30-87	14	No
Ele's & Harsons	12-31-87	17	No
377 Main, Region 10	10-5-87	12	No
Hawthorne	3-31-88 ✓	23	No
REM-Waite Park	8-30-88	9	No
Dungarvin I	8-1-88	15	15
Dungarvin-Balbrigen	8-1-88	6	6
Dungarvin-Camara	8-1-88	6	6
Forestview-Logan	5-28-88	6	No
Greenbrier	5-31-88 ✓	165	No
Stevencroft	6-30-88	6	No
Valor-James	9-30-88	6	No
Wicklough	6-30-88 ✓	100	No
Family House	5-88	7	No
Petits Children	2-88	15	No
Resident. Alt, Wright	1-89	8	No
Urlingford	1989	15	6
Hammer	8-1-89 ✓	46	No
REM-Sauk Center	1989	7	No
Shelton	8-89	8	No
REM-Redwood	12-30-90	132	12
Valor-Aspen	8-31-90	6	6
Valor-Hemingway	7-31-90	6	6
Valor-Kentucky	7-31-90	6	6
Valor-Vincent *	7-31-90	6	6
Chai House	12-90	6	6
Valor-Minnetonka	7-31-90	6	6
Tikvah	12-90	6	6
Valor-Lexington	7-31-91	6	6
Valor-Sunlen *	7-31-91	6	6
Hearthside *	8-7-91 ✓	40	24
Dungarvin-Shire *	9-30-91	12	12
Woodvale III *	6-30-92	41	6
		1003	108
Net Reduction	895		

\* In process of closing

1985-1992

## APPENDIX B

FACILITIES OVER 15 BEDS

RESIDENT LEVELS OF CARE

Number of Facilities by Size  
(Number of Licensed Beds)

B-1

Source: Long Term Care Management Division

Division for Persons with Developmental Disabilities

Number of Beds	1-10	11-15	16-40	41-75	76+	# People (beds) in facilities over 15
Region 1	10	2	1			33
Region 2	3	3				
Region 3	17	8	3			53
Region 4	24	2				
Region 5	3	5	1			16
Region 6	1	11	1	1		76
Region 7	12	9	3			79
Region 8	3	7	1	1		63
Region 9	11	11		1		44
Region 10	15	14	7	2		227
Region 11	79	26	9	7	3	954
	178	98	26	12	3	317 total facilities
# people (beds)	1235	1357	593	643	309	4137 total people

222  
1235  
1357  
593  
643  
309  

---

4137

Over 15  
41 facilities  
1545 people

70% MA DTH  
317 ICFMR  
4000 residents

Facilities with 76+ beds - 3**A**

Region 11	<u>Beds</u>
Portland Residence Inc.	101
Clara Doerr - Lindley Hall	103
Norhaven	105
Total	309

Facilities with 41-75 Beds - 11

<u>Region-# of Facilities</u>	<u>A Beds</u>	<u>B Beds</u>	<u>Region Total</u>
6-1 Kindlehope	60		60
8-1 Home for Creative Living		45	45
9-1 Harry Meyering		44	44
10-2 Hiawatha Children's		43	
Vasa Lutheran		50	93
11-7 Dakota Children's		48	
Phoenix Residence		51	
Orvilla		54	
Mt. Olivet Rolling Acres		56	
Homeward Bound		64	
Lake Owasso		64	
Lutheran Hope & Home		64	401
TOTAL	60	583	643

Note re: 2 additional facilities:

(REM Redwood Falls (67 beds) will be closed by 12/31/90)  
 Woodvale III (41 beds) has signed closure agreement

Number of Facilities by Size  
(Number of Licensed Beds)

8-1

Source: Long Term Care Management Division

Number of Beds	1-10	11-15	16-40	41-75	76+	# People (beds) in facilities over 15
Region 1	10	2	1			33
Region 2	3	3				
Region 3	17	8	3			53
Region 4	24	2				
Region 5	3	6	1			16
Region 6	1	11	1	1		76
Region 7	12	9	3			79
Region 8	3	7	1	1		63
Region 9	11	11		1		44
Region 10	15	14	7	2		227
Region 11	79	26	9	7	3	954
	178	98	26	12	3	317 total facilities
# people (beds)	1235	1357	593	643	309	4137 total people

222  
1235  
1357  
593-  
643-  
309  
-----  
4137

Over 15  
41 facilities  
1545 people

70% MA DTH  
317 ICFMR  
4000 residents

Division for Persons with Developmental Disabilities

Facilities with 16-40 Beds - 26

<u>Region-# of Facilities</u>	<u>A Beds</u>	<u>B Beds</u>	<u>Region Total</u>
1-1 REM Roseau		33	33
3-3 Northome Nursing Home	16		
Residential Serv. of NE MN II		16	
Range Center		21	53
5-1 Oakridge Home		16	16
6-2 Group Living Home	16		16
7-3 Granite Care Home	23		
REM - Fernwood Inc.		24	
Madden Kimball Home	32		79
8-1 Prairie View Inc.		18	18
10-7 Adams Group Home		16	
Fillmore Place		16	
Inisfail, Inc.		16	
Rainbow Residence		16	
REM - Park Heights		16	
Hiawatha Adult Home		22	
Woodvale V		32	134
11-9 Greenwood Residence East		16	
Demars Children's Home		20	
Hammer Res. (Apt. & Annex)	21		
Northeast House Inc.	24		
St. Ann's Residence	30		
Homeward Bound Brooklyn Park		32	
People's Child Care Residence		32	
REM - Pillsbury Inc.	34		
Camilia Rose Group Home	—	35	244
TOTAL	196	397	593

In addition, Trevilla of Robbinsdale has 132 nursing home beds, 32 of which are used for persons with developmental disabilities.

## Residents by Level of Care in 40+ Bed Facilities

<u>76+ Bed Facilities</u>		<u>Min.</u>	<u>Min.- Mod.</u>	<u>Mod.</u>	<u>Mod.- Max.</u>	<u>Max.</u>	<u>Total</u>
Portland		23	8	46	10	7	
Norhaven		30	6	57	2	6	
<u>Class Over</u>		<u>54</u>	<u>14</u>	<u>103</u>	<u>12</u>	<u>13</u>	
<u>41-75 Bed Facilities</u>							295
6	Kindlehope	19		36	2	3	
8	HCL				34	10	
9	Harry Meyering	4		7	13	20	
10	Hiawatha Ch's.				35	8	
	Vasa Lutheran	2		27	6	15	
11	Dakota Ch's.			3	35	8	
	Phoenix			4	33	11	
	Orvilla	3	1	27	13	8	
	Mt. Olivet		1	21	21	12	
	Homeward Bound	1		4	55	9	
	Lake Owasso	2		22	10	30	
	Lutheran Hope & Home	<u>3</u>	<u>3</u>	<u>29</u>	<u>6</u>	<u>11</u>	
		<u>34</u>	<u>5</u>	<u>180</u>	<u>263</u>	<u>145</u>	
		5.4%	1%	29%	42%	23%	

627

TOTAL 40+	151	24	313	276	158	922
	16%	3%	34%	30%	17%	

Source: Quality Assurance Reviews, Department of Health,  
Division for Persons with Developmental Disabilities

## Residents by Level of Care in 16-40 Bed Facilities

Facilities	Min.-		Mod.-16-40		Bed	
	Min.	Mod.	Mod.	Max.	Max.	Total
REM Roseau	1		2	20	6	
Northome						
Residential Services				9	4	
Range Center			5	9	7	
Oakridge			1	9	6	
Group Living Home				8	8	
Granite Care Home	8		12	1	2	
REM Fernwood			3	15	6	
Madden Kimball			12	6	10	
Prairie View				12	6	
Adams			2	9	5	
Fillmore			1		15	
Inisfail			1	10	5	
Rainbow				11	5	
REM-Park Heights			1	6	9	
Hiawatha				13	8	
Woodvale V	4	3	12	8	4	
Greenwood Res. East						
Demars Children's Home			3	10	7	
Hammer Res.	4	4	12			
Northeast House	12		8	4		
St. Ann's	2	1	18	7	2	
Homeward Bound				26	6	
People's				32		
REM-Pillsbury	8	2	22	1	1	
Camilia Rose	3	2	14	8	7	
	42	12	129	234	129	546
	8%	2%	24%	43%	24%	
TOTAL 16+	174	36	406	508	284	1408
	12.3%	2.5%	28.8%	36%	20.1%	



## APPENDIX C

### ICF-MR DOWNSIZING PLAN

#### ADVISORY COMMITTEE

Advisory Committee  
Downsizing Large ICFs/MR

C-1

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APPENDIX D  
EVALUATION OF EACH SCENARIO ACCORDING TO CRITERIA

SCENARIO I

In Scenario I, all existing ICF-MR facilities over 10 beds would either close or be reduced in size until there were no facilities more than 10 beds.

A. Extent of Match with Policy Direction

This scenario is most consistent with overall policy direction.

It fully implements and complies with existing statutory language regarding 15-bed and 10-bed limitation on placements from regional treatment centers.

B. Respect for Individual Needs/Choice

Creates smallest and most individualized alternatives.

Limits choices for persons who want to stay in large facilities.

C. Extent of Address of Safety/Privacy/Programmatic Issues

More cost and more effort will be involved to address safety & staffing needs of individuals in new smaller facilities.

Will allow for most effective address of individual needs regarding safety, privacy, and other programmatic needs.

D. Extent of Redesign for Overall Community Capacity .

Community alternatives would have to be developed for a larger number of individuals, many of which have higher needs.

Development of sufficient number of community alternatives will require intense provider, county, and state planning and commitment of resources.

Development of crisis/short term care services will likely be more difficult in smaller facilities.

E. Cost

Most costly.

SCENARIO II

In Scenario II, all facilities are decreased in size (either closed or downsized) to no more than 15 beds.

A. Extent of Match with Policy Direction

Consistent with overall policy direction, but less than Scenario I. If 10-bed statutory limitation is in effect in 1993, forces another cycle of change in two years.

B. Respect for Individual Needs/Choice

Does create new community alternatives and choices for persons preferring smaller settings, but not as much as I.

Allows more choice than I and III for persons preferring to stay in existing intermediate-size facilities.

- C. Extent of Address of Safety/Privacy/Programmatic Issues  
Effort and resources involved to accommodate individuals' safety, privacy, and other programmatic needs not as extensive as I, more than III and IV.
- D. Extent of Redesign for Overall Community Capacity  
Some current facilities could convert to accommodate individuals with higher needs.  
A higher level of ICF-MR capacity is maintained as part of the service system (more existing facilities would stay in existence than I).  
Some current facilities can be used to develop capacity for crisis and short term care.
- E. Cost  
Less costly than I, more than III and IV.

### SCENARIO III

Scenario III is not as aggressive a change as Scenarios I and II, but offers significant change from the current system. In Scenario III, the largest A facilities are closed. Existing B bed facilities may be maintained at their current size. However, if a B facility wished to downsize without closure, they would be allowed to do so based on a per-facility determination. Downsizing on a limited basis (up to 25%) would occur if there was a need based on safety issues, such as conversion of former children's facilities to adult facilities, or to develop the capacity for crisis services and short-term stays. Any Class A facility over 16 beds would closed, and current 16-bed Class A facilities would be downsized to 15 or less.

- A. Extent of Match with Policy Direction  
15-bed requirement would have to be changed, or exceptions allowed. Creates smaller 15-bed facilities and allows some large facilities to remain and become more specialized.
- B. Respect for Individual Needs/Choice  
Offers fewer choices for people who wish to leave existing B facilities for smaller alternatives.  
More choices than I and II for those who wish to remain in existing B facilities. For those in intermediate size A facilities, fewer choices to stay in existing facilities, but offers more choice for those who wish to live in an ICF-MR.
- C. Extent of Address of Safety/Privacy/Programmatic Issues  
Costs involved would be to upgrade to allow existing large and intermediate class B facilities to accommodate safety, privacy, and other programmatic needs, due to changes in population toward those with higher needs.
- D. Extent of Redesign for Overall Community Capacity  
Current B facilities would need to be assisted to accommodate individuals with higher needs and those in need of crisis or short-term services.

Leaves more ICF-MR capacity and fewer small community homes in the system than Scenarios I and II, but more small homes than the current system. Some current class B facilities can be used to develop capacity for crises and short term stays.

E. Cost

Less expensive than Scenarios I and II. Some costs are in development of smaller community alternatives, and some in upgrading current facilities to accommodate individuals with higher needs.

#### SCENARIO IV

Scenario IV would allow each facility to downsize on an individualized schedule, basically by attrition and moving people to the Medicaid waiver. Everyone in either class A or class B facilities who could be served within the waiver fiscal limits would be given the opportunity to exit based on their desire. A mechanism would be adopted into Rule 53 allowing the restructuring of rates to account for the open bed requirement. The mechanism would be utilized on a timed basis and not every time that a person leaves. No facilities would be closed. If this movement to the waiver and down-sizing were made viable, the cost estimates in this option assume that these facilities would downsize.

A. Extent of Match with Policy Direction

Least match with overall policy direction. Does not allow implementation of 15-bed requirement. Does not close any facilities.

B. Respect for Individual Needs/Choice

Does provide options for individuals who wish to move to smaller community homes, but only those who can be served within the Medicaid waiver average. Allows the most choice for individuals who wish to remain in existing large homes.

C. Extent of Address of Safety/Privacy/Programmatic Issues

Physical plants could be modified to accommodate safety, privacy, and other programmatic needs as facilities gradually became smaller. Closed units could be modified for crisis intervention and short term respite stays in Class B facilities. Expenses would go to building modification.

D. Extent of Redesign for Overall Community Capacity

Could allow systematic planning for development of smaller community alternatives, but only those options fitting within the Medicaid waiver average.

E. Cost

May be least costly in terms of development of small community alternatives, but also projects least amount of savings to state through downsizing of current facilities. In addition, current facilities continue to remain

funded, and a significant proportion of total resources is going to readjusted rates. May be the most expensive to administer, in terms of rate adjustments. More dollars would be expended for existing facilities to serve fewer residents than would be expended on development of community alternatives. At some point of downsizing, it would also become more cost effective to simply close the facility and serve individuals in other settings than to adjust the rate to keep the existing facility operating.

## APPENDIX E

### PROGRAMMATIC AND COST ASSUMPTIONS USED IN SCENARIO DEVELOPMENT

The programmatic assumptions used in the development of all scenarios and recommendations were:

1. Any major downsizing or closure effort will require appropriate statutory and rule authorizations. Use of building space and other issues will be addressed in the rate-setting and need determination processes.
2. Any downsizing or closure of any facility would go through need determination process, including host county and other counties in the region.
3. It is feasible for some intermediate and smaller facilities to downsize, as they do A to B conversions. In these conversions, a certain amount of downsizing is allowed, within administrative limitations and property limits.
4. 6 to 10 bed facilities are not covered in the legislation mandating the Department to develop an ICF-MR downsizing plan. They are already in compliance with the 15-bed rule. They can do A to B conversions to downsize.

The cost assumptions used in the development of these alternatives include:

1. Cost of continuing as is, no change - deducted; only new costs represented.

#### Scenarios I and II:

2. New development:

60% of beds - new small ICF-MR development; 6 bed homes; \$162.65 per diem  
40% of beds - Medicaid waiver; \$97.18 total per diem

#### For All Scenarios:

3. Cost of closure - estimated at \$60 above current average rate in that group for first year; increased by 6% inflation each year thereafter

4. Phase-in assumptions:

FY 92 - spent planning; no facilities open until third quarter FY 93

For facilities downsizing with no closure - 8% savings for facilities downsizing up to 25%; 3% average savings used for smaller facilities downsizing less than 25%

5. Administrative costs:

Additional staff required in auditing, licensing and certification, etc.

**MINNESOTA STATE PLAN  
FOR SERVICES TO PERSONS  
WITH MENTAL RETARDATION  
AND RELATED CONDITIONS**

**January 15, 1987 to January 14, 1989**

**Minnesota Department of Human Services  
Mental Retardation Division  
January 15, 1987**





STATE OF MINNESOTA  
DEPARTMENT OF HUMAN SERVICES  
CENTENNIAL OFFICE BUILDING  
ST. PAUL, MINNESOTA 55155

January 15, 1987

Dear Citizens of Minnesota:

On behalf of Governor Rudy Perpich and members of the staff of the Department for Human Services, I am pleased to present this state plan for mental retardation services. This plan covers the period from January 15, 1987 to January 14, 1989, and is submitted in keeping with Minnesota Statutes, section 252.291, subdivision 3 (d).

I hope that many citizens will take the time to read this plan and will support the initiatives outlined herein. We believe that the principles of service delivery described in the System Design section of the plan constitute an excellent blueprint for future initiatives on behalf of people who are developmentally disabled.

Sincerely,

  
SANDRA S. GARDEBRING  
Commissioner

1987-1989 STATE PLAN FOR  
SERVICES TO PERSONS WITH MENTAL RETARDATION  
AND RELATED CONDITIONS

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## DEPARTMENT OF HUMAN SERVICES

### MISSION STATEMENT

The Department of Human Services, in partnership with the Federal Government, county, and other public, private, and community agencies throughout Minnesota, is a state agency directed by law to assist those citizens whose personal or family resources are not adequate to meet their basic human needs. It is committed to help them attain the maximum degree of self-sufficiency consistent with their individual capabilities. To these ends, the Department will promote the dignity, safety, and rights of the individual, and will assure public accountability and trust through responsible use of resources.

## INTRODUCTION

### A. Authority for Plan

Minnesota Statutes, section 252.291, subdivision 3(d), requires the Commissioner of Human Services to develop a state plan for the delivery and funding of residential, day, and support services to Minnesota's citizens with mental retardation and related conditions and to submit that plan to the clerk of each house of the Minnesota Legislature on or before the 15th day of January of each biennium beginning January 15, 1985.

### B. Definition and Scope of Developmental Disabilities

As a result of efforts by a coalition of organizations, the 1985 Legislature passed a bill which updated many obsolete references to persons with mental retardation and mental illness. This bill also makes persons with "related conditions" eligible for services previously provided only to persons who are mentally retarded. "Related conditions" is defined as follows:

A person has a "related condition" if that person has a severe, chronic disability that is (a) attributable to cerebral palsy, epilepsy, autism, or any other condition, other than mental illness, found to be closely related to mental retardation because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation or requires treatment or services similar to those required for persons with mental retardation; (b) is likely to continue indefinitely; and (c) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, or capacity for independent living. (M.S. Chapter 252.27, Subd.1)

While the largest proportion of those labeled developmentally disabled are persons with mental retardation (75 percent), other individuals who have cerebral palsy, epilepsy, autism, and other disabilities may be developmentally disabled if they also meet the criteria of severity, chronicity, age of onset, and substantially limited functional abilities .

The population of persons who are developmentally disabled in Minnesota is estimated at 101,470. This estimate is based on a prevalence rate of developmental disabilities of 2.42 percent of the state's 1985 population. However, less than 1 percent (or 41,900 people) of Minnesota's total population would probably be receiving services in the state's system.

For purposes of this planning document, "persons with mental retardation and related conditions" and "persons with developmental disabilities" will both be used within the context described above.

### **C. Terminology**

In keeping with contemporary practice in the field of developmental disabilities, it is the policy of this administration to avoid all archaic, stigmatizing, dehumanizing, and syntactically incorrect terminology and replace such language with appropriate socially valued references that emphasize the humanity and individuality of people with disabilities.

## **HISTORICAL PERSPECTIVE**

### **A. Chapter 312, Laws of 1983**

Minnesota was an early leader in the development of community-based intermediate care facilities for persons with mental retardation (ICFs/MR). According to the February 11, 1983 report by the Legislative Auditor, Minnesota's population in community-based ICFs/MR was, on a per capita basis, higher than that of any other state (Legislative Auditor, 1983, p.12). The Legislative Auditor's report found that over reliance on ICFs/MR had been very costly because of the state's long-term investment in property and buildings. The report noted that "alternatives to ICFs/MR care, such as semi-independent living services (SILS) and foster care, lack stable funding and are not well-developed." It was recommended that the availability and use of alternative forms of residential care be increased, existing facilities be encouraged to serve more dependent individuals, and development of new ICFs/MR be limited. (Office of the Legislative Auditor, 1983)

### **B. Legislative Moratorium of ICFs/MR**

A legislative moratorium on development of ICFs/MR beds was embodied in Laws of 1983, Chapter 312, article 9. The moratorium was effective June 10, 1983, and required that under no circumstance could the number of beds, in the community and in regional centers combined, exceed 7,500 on July 1, 1983 or 7,000 on July 1, 1986.

On December 31, 1983, there were 2,417 ICF/MR beds in the regional centers and 5,036 in the community, for a total of 7,453. In addition, there were 213 more beds that had been approved for development prior to the moratorium, but were not yet open.

### **C. County Case Management**

In an effort to gain control of these widely dispersed programs, and to convert services from provider-driven to client (needs) - driven, the legislature mandated a decentralized, county-based program using county case managers to authorize individual services.

The 1985 Legislature passed Minnesota Statutes, section 256B.092, which established policies for the provision of case management to persons with mental retardation or a related condition and mandated that permanent rules be promulgated by July 1, 1986. This direction was consistent with the 1979 Community Social Services Act which gave planning and social service administrative responsibilities to the counties.

In 1986, Minnesota Department of Human Services Rule, parts 9525.0015 to 9525.0165 established standards for the provision of county case management with regard to persons with mental retardation and related conditions. The rule defines case management services as identifying

the need for, planning, seeking out, acquiring, authorizing, and coordinating services. Case management services also include monitoring and evaluating the delivery of services to, and protecting the rights of, persons with mental retardation and related conditions.

**D. Rule 53 and Determination of Need**

The Legislature authorized the development of a new rate structure in 1983 which emphasized payments for services rather than buildings and administration. It also authorized counties to make recommendations to the Commissioner on the number, type, and location of new facilities and programs (determination of need) and required a county redetermination of need for existing services every two years.

**E. Home and Community-Based Services Waiver**

In 1983, the Minnesota Legislature directed the Department of Human Services to apply for a waiver from federal regulations to use Medicaid to support home and community-based services for persons with mental retardation and related conditions. Minnesota's reliance on regional centers and community ICFs/MR had resulted in a service system in which individuals were matched with services on the basis of what was available rather than on what was needed. A key objective of the home and community-based services waiver was to develop residential and habilitation programs that were tailored to the needs of individuals.

Another objective of the home and community-based services waiver was to provide assistance to families whose children or adult family members were "at risk" of placement in a regional center or community ICFs/MR. These in-home services include respite services, as well as visits from trainers, therapists, home-makers, and others. The Medicaid waiver may also pay for the costs of making minor physical adaptations to homes.

In addition to the residential and in-home services, the home and community-based services waiver supports the costs for day programs and county case management services.

**F. Welsch Consent Decree**

In the past 25 years, several forces have changed Minnesota's state regional center programs for persons with mental retardation. As in many other states, litigation has been one of the most important forces. In 1972, parents of Minnesota regional center residents successfully challenged the programs and care provided at the centers in a federal court suit. The case, now known as *Welsch v. Gardebring*, has continued to this day. In 1980, the parties ended one phase of the case by agreeing to a consent decree. The state agreed to make program and staffing changes at the regional centers and to reduce the number of residents with mental retardation from 2,710 to 1,850 by 1987. The decree will expire on July 1, 1987.



## **CURRENT STATUS**

### **A. ICFs/MR Beds**

As required in the Laws of 1983, Chapter 312, Minnesota has been reducing its use of and reliance on ICF/MR care by providing alternative community services. In 1983, Minnesota had 7,453 certified ICF/MR beds. Currently, Minnesota has 7,127 certified ICF/MR beds (only 6,800 beds are being used). The Department is submitting the additional certified beds to the Department of Health to remove them from the state statistical totals.

In addition, community ICFs/MR are serving more severely handicapped persons aided in some cases by use of special need rate funding and one time rate adjustments. With Minnesota's adoption of the 1985 Life Safety Code for ICF/MR facilities, many small (16 or fewer persons) ICFs/MR will likely modify their programs to serve more dependent persons as needed and recommended by county boards. Four facilities are currently undergoing such modifications and new proposals are expected at a rate of one facility per month.

Since 1980, 845 ICF/MR beds have been decertified in state regional centers. In F.Y. 1986, state regional centers experienced a significant net reduction of 209 in their population of persons with mental retardation. Twenty children having very severe disabilities were placed in community programs, primarily through the use of home and community based waiver services.

The Welsch v. Gardebring regional center population reduction target to 1,850 by July 1, 1987, was achieved in April, 1986, over one year ahead of time.

### **B. Case Management**

Since the spring of 1985, county social service agencies have been working to achieve compliance with case management standards. Since each county's ability to achieve compliance is dependent upon the training and experience of their case managers in the field of mental retardation, the size of case managers case loads, and the administrative and supervisory support available to them, most counties needed additional time to achieve full compliance with case management standards. All counties are required to be in compliance by July 1, 1987.

However, outstanding issues in regard to county case management remain, including: (1) lack of sufficient staff in some counties to provide adequate and effective case management for all eligible clients; (2) need for more intensified training of county case managers; and (3) need for evaluation and review of case management effectiveness and consumer satisfaction.

### **C. Rule 53**

The new rules governing medical assistance reimbursement of ICFs/MR (Rule 53) were effective January 1, 1986. The 1985 Legislature mandated that the Commissioner of Human Services study mechanisms of reimbursement based on client needs, for ICFs/MR providers, training and habilitation agencies, and wavered services. The Department contracted with Lewin and Associates, a Washington, D.C., based consulting firm, to research reimbursement mechanisms and to make recommendations to the state on implementation of a new system. The state will modify the existing medicaid reimbursement rules to allow a targeting of dollars based on the differences in client need and resource use so there is no longer a disincentive to serve clients with greater needs. The results of this study are due by July 1, 1987.

### **D. Home and Community-Based Waiver**

In April, 1984, the Department secured federal approval of a Medicaid waiver to provide home and community-based services to persons with mental retardation who otherwise would have remained in or been placed into a community ICF/MR or state regional center. The waiver was approved from July 1, 1984, through June 30, 1987.

The use of the waiver program by counties has increased dramatically over the last two years. Currently, there are over 700 persons receiving home and community-based services with an additional 300 persons who will be served by June 30, 1987.

	<u>Persons Served</u>
July 1, 1985	230
July 1, 1986	567
July 1, 1987	1,000

### **E. Welsch Status and County Use of Regional Centers**

The Welsch Consent Decree is scheduled to terminate July 1, 1987, if the Department can demonstrate substantial compliance.

The Department believes it has made significant progress in demonstrating compliance in the following areas:

1. Reduction of the population of children in regional centers from over 250 in 1980 to 26 presently.
2. Reduction of regional center population from over 2,600 in 1980 to 1,770 presently. See Appendix A. for county utilization of state regional centers.
3. Development of alternative community services and funding options which have resulted in reduced regional center admissions.
4. Reduced reliance on psychotropic medications in regional centers.
5. Reduced reliance on separation and mechanical restraints and other aversive or deprivation procedures.

The Department is seeking to resolve compliance issues identified by the plaintiffs/Court Monitor which affect the Department's ability to demonstrate substantial compliance. The following is a partial listing of those issues:

1. Lack of sufficient community service options.
2. Lack of performance standards for service providers based on client outcome measures.
3. Lack of sufficient trained staff in both community residential and day services, as well as regional centers.
4. Continued reliance on the use of separation, seclusion, and mechanical restraint for a portion of class members residing in regional centers.
5. Lack of sufficient specialized equipment and qualified habilitation staff to provide and supervise services for physically disabled residents of regional centers.

#### **F. Other Community Services**

##### **1. Semi-Independent Living Services (SILS)**

Semi-Independent Living Services is a state and county grant program which includes training, counseling, instruction, supervision and other assistance required by a person's individual service plan. It may also include assistance in budgeting, meal preparation, shopping and personal appearance. SILS assures the placement of residents of ICFs/MR into independent living settings, the prevention of inappropriate placements into ICFs/MR, and increased independence for persons with mental retardation or related conditions who are no longer eligible for ICFs/MR or waived services.

Over 800 persons are receiving SILS from 80 different licensed vendors. Seventy-nine counties are participating, and the average annual cost per person is approximately \$4,600 (65 percent state, 35 percent county). Moreover, counties provide SILS to additional persons who do not have mental retardation or related conditions and, therefore, are not eligible for state grant funds.

There are 410 persons identified as eligible for SILS who are not being served due to limited state appropriations for this program. The major issues in this program are: (1) the lack of availability of SILS to enable persons no longer eligible for nor requiring ICF/MR or waived services to live more independently in the community; (2) insufficient state appropriation to fund SILS at the 80 percent reimbursement level required in state law; and (3) current allocation methods which do not provide sufficient incentives to increase program efficiency and effectiveness.

## **2. Family Subsidy Program**

Consistent with state policy of preventing unnecessary separation of children from their families, this program provides funds to counties to reimburse families with severely disabled children up to \$250 per month for specific items or services which are needed in order for the child to remain in or return to their natural or adoptive home. The grants pay for such items or services as medical insurance deductibles, medications, day care, respite care, special clothing, diet and equipment, and medical transportation.

Currently, there are 250 families receiving grants in 44 different counties. Over 70 percent of the children who are benefiting from grants have severe or profound mental retardation. There are 130 known eligible families waiting for a family subsidy grant which cannot be allocated due to limited appropriations.

## **3. State Operated Community Services**

The Laws of 1985 authorized pilot projects to demonstrate the feasibility of state operated community services for state regional center residents with mental retardation. The Commissioner issued a request for proposal in December 1985 for such projects. Cambridge Regional Human Services Center and Faribault Regional Center were selected to develop pilot projects for up to 20 residents each. As of January 1, 1987, 12 persons with mental retardation from Cambridge Regional Human Services Center and Faribault Regional Center had been moved into state operated community services using a shift-staffed, four resident model. Follow-up evaluations are planned at six-month intervals to determine pilot projects' effectiveness.

## **4. Day Training and Habilitation Agencies**

Training and habilitation agencies provide services to approximately 5,000 adults and 1,600 children. Most of the children receiving services are under age four years. Day services are provided by 110 agencies at 155 licensed community sites. More than 60 percent of adults receiving services live in ICFs/MR. The remaining 40 percent live in their own homes or in an adoptive home (23 percent), licensed adult foster care (7 percent), or another living arrangement.

Pro grammatically, the mission of service delivery is shifting from center-based health and social services, to community integrated services designed to achieve chronologically age appropriate outcomes for adults. This shift is resulting in the development of more diverse employment options for adults with mental retardation or related conditions.

As the adult service system more clearly defines its mission to include age appropriate services in the least restrictive environment a concomitant shift away from service delivery to children is occurring. As a result, more children are being served in public schools.

## SYSTEM DESIGN

### Values and Methodologies

Designing programs to serve individual human beings cannot be done in a value-free atmosphere. Consciously or unconsciously, attitudes and values toward children and adults with developmental disabilities are reflected in the behavior and attitudes of care givers, in the location, size, and appearance of the environment in which services are provided, and in the selection of tools or materials to be used in delivering those services.

For example, we believe that our primary focus should be on the needs of the person with disabilities, that support of family and care givers is necessary to help accomplish that task but should not obscure it, that the "system" should be based on the individual, and that human relationships are more important than bricks and mortar.

The following are concepts which have become generally accepted by parents and professionals as "best practices" to be followed in the field of developmental disabilities.

#### 1. Normalization

The most basic and effective concept in establishing a service system is the concept of normalization. It means making available to people with mental retardation the same patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society. Normalization is a deceptively simple concept. It has been mistakenly assumed to mean "making people normal" (a cure) or "making everyone behave the same" (regimentation).

Outcomes or normalization goals have traditionally been stated in terms of persons who are developmentally disabled achieving independence. Considering the severity of some handicapping conditions, it is more accurate to state such goals in terms of individuals achieving measurable reductions in their dependencies and reaching levels of interdependence closer to the norm for non-handicapped individuals, all of whom are dependent on other people at different times in their lives. (Metropolitan Council, 1985)

#### 2. Community Integration

This is a corollary to the principle of normalization and simply means that all services should enable persons with developmental disabilities to be visible and active participants in their communities. Because people with the most severe learning disabilities have difficulty transferring or generalizing knowledge from one environment to another, and because research has demonstrated how powerful imitation or role-modeling can be for children and adults with developmental disabilities, training should occur in

the setting where the behavior will be used. This means that residential programs would be provided in the person's home which is located in community neighborhoods where people without handicaps live. It also means that persons with developmental disabilities should be educated and integrated in their neighborhood schools, obtain health services in physicians' offices, work in community industries or businesses, receive religious nurture in churches or synagogues, and participate in recreational activities in community sports facilities. This plan recommends that service settings should never totally segregate persons who are handicapped from those who are not.

The concept of "partial participation" means that adaptations to activities and environments be made for individuals so they can participate in some way, using the same community resources available to those who are not handicapped. This principle affirms that persons with severe mental or physical handicaps have a right to participate, to whatever extent possible, in the life of their communities. Similarly, "natural proportion" provides an operating practice wherein programs, settings, and individual goal selection are designed so that persons with developmental disabilities can regularly interact with more non-handicapped people than handicapped people approximate to that ratio in the total population. (Metropolitan Council, 1985)

### 3. Support, Not Supplant, The Natural Home

The Mental Retardation Division supports and adheres to the policy of this state that all children, regardless of minority racial or ethnic heritage, are entitled to live in families that offer a safe, permanent relationship with nurturing parents or caretakers and have the opportunity to establish lifetime relationships. This policy is generally referred to as permanency planning and was adopted by the Minnesota Legislature as Chapter 9, Section 69, 1985 Special Session Laws of Minnesota amending Minnesota Statutes, section 256F.01 (PUBLIC POLICY).

### 4. Age Appropriateness

Nothing is more fragile than a person's image. In the past, adults with mental retardation or related conditions have been viewed as eternal children, incapable of growth and personal maturity. The inappropriate use of psychological test scores or "mental ages" as a simplistic means of assessing a person's capacity for learning resulted in a self-fulfilling prophecy that severely limited the potential of the person, more severely than did the disability itself. Therefore, it is the responsibility of the state to support positive imagery in environments designed to serve people with developmental disabilities.

### 5. Real Jobs, Real Homes, Real Schools

For many years services were provided according to a developmental model. This model derived from an early childhood education

premise that all individuals grow and learn in sequential stages and that mastery of each stage of development is required before the next stage can be attempted. This resulted in teaching persons with developmental disabilities the skills and behaviors typically learned in each stage of growth from infancy to childhood to adolescence to adulthood. Too often, in adhering strictly to the developmental model, age-inappropriate goals and strategies were selected for those who were already adults. Inability of developmentally disabled persons to move quickly through the developmental stages led to the realization that it might take several decades, perhaps a lifetime, for them to acquire critical self-care, vocational, and socialization skills using a strictly developmental approach.

Current professional theory now requires use of the "Criterion of Ultimate Functioning." The most critical skills to be taught are those that are critical to develop the personal behaviors needed to function to one's maximum capability in domestic, educational, vocational, and social situations. Therefore, this plan supports the concept that the skills and behaviors which are necessary for integrated community life and that are valued by the individual and society should have priority when selecting goals and services. (Brown, Nietupski and Hamre-Nietupski, 1976)

## **B. Service Coordination and Quality Assurance**

In the past 15 years, there has been an unprecedented expansion in the number of community-based services throughout the nation and in Minnesota. Many new services and personnel have entered the developmental disabilities service system. While this period of rapid expansion has alleviated some of the system capacity needs, it has also given rise to several problems centering on the quality of services. Although the services must meet certain minimum regulations, they vary considerably in the quality of operating practices and client outcomes.

### **1. Service Coordination**

Case management is increasingly seen by parents and professionals as a vital link to the complex service system. Effective case management requires a variety of responsibilities. Case managers must be able to assess the client's strengths, limitations, and needs based on a variety of information sources. They should be able to work with clients and their families in developing individual service plans. They should have current knowledge about what and where services are available and keep abreast of advances in service technology. They should act as brokers to link their clients to the services they need. They should monitor a client's progress through direct observations, interviews, and data collection. They should act as class advocates for clients, representing their interests so that deficiencies in the service system can be corrected. (Metropolitan Council, 1985)



## 2. Quality Assurance

Licensing, client advocates, and quality assurance staff in regional centers, as well as other state and county monitoring groups can, and do, provide some safeguards to assure quality of services. In addition, as pointed out by the Legislative Auditor in describing, "planning for the 'post-Welsch' era," there is a "need for continued outside monitoring and scrutiny of the regional centers and community facilities and programs. The experience of the past five years suggests that this outside scrutiny is needed to ensure that the hospitals do not retreat from the progress they have made and to point out areas where improvements are still needed."

The Developmental Disabilities Program, State Planning Agency, expresses the view that the most critical problem in Minnesota today is the issue of quality, outcomes, and appropriateness of services. Some opportunities exist to promote quality:

- . Implement mandatory training for all staff who work with people with developmental disabilities.
- . Provide clear guidelines to counties and providers that services should lead to outcomes such as increases independence, integration, and productivity. Collect data on outcomes and provide feedback to providers.
- . Implement performance-based contracting rather than purchase of service arrangements.
- . Provide a means of independent verification of good practice through monitoring set up outside DHS. Use volunteer committees as one example.
- . Establish a mechanism to give positive recognition to providers and agencies rather than only focusing on negative actions.
- . Work with counties and providers to determine how best to monitor dispersed settings. Traditional approaches of licensing are very limited in assuring quality supported employment and supported living services.

The Department recognizes that significant amounts of public resources are expended on services for persons with mental retardation. Part of quality assurance means maximizing the use of those resources for the appropriate levels of services. The Department is committed to efforts that will allow appropriate persons to become independent of the public service funding.

## GOALS 1987-1989

### A. Staff Training

Approximately 6,000 staff members provide residential, social, and employment support to persons with developmental disabilities. Staff training is provided to a greater or lesser degree, according to one or more of the following variables: (1) rules of the Department, including licensure, case management, day program or residential; (2) federal funding requirements (e.g., ICFs/MR regulations; and (3) commitment to training and/or resource availability of individual service providers.

What is needed is a "floor," a basic level of staff training required before staff are permitted to provide care to persons with developmental disabilities. The Department is proposing a legislative initiative which will supersede and standardize training requirements found in various rules governing services. It would amend Minnesota Statute, section 252.28, to authorize the Department to establish minimum training requirements for case managers and direct care staff.

In addition to entry level training, the Department is committed to assuring that employees in both the public and private sector are aware of advances in the field of developmental disabilities. Recent government supported research and demonstration projects in education, vocational training, and community residential services have produced improved teaching techniques, innovative theories of service delivery, and impressive data on achievements of severely handicapped learners. New technological devices and equipment have enabled persons with severe handicaps to improve their communication, mobility, and learning ability and open a wide range of educational, vocational, and social opportunities previously closed to them.

### B. External Monitoring

Paid staff (licensing, Health Department, county case managers, etc.) do a good job of providing quality assurance for the people we serve. However, there is also a role for parents and interested citizens to help provide external monitoring of services. Therefore, the Department will request passage of legislation to fund "and authorize such a program.

The following recommendations were taken from a December, 1986 report by Temple University professionals based on their extensive analysis of quality assurance in dispersed community programs and reflect the elements that would be in such a program for Minnesota.

Given the limitations of our service system (or any service system), no "Quality Assurance System" can really assure that high quality services are always delivered to every person. By itself, no such system is sufficient; there are other factors that are necessary. For example, in a system in which the average case mana-

ger's case load is over 100 individuals, or in which there is little or no value-based training, or in which required training is only on-the-job or extremely brief, or in which the salaries of the direct care personnel are abysmally low and turnover is very high, no "Quality Assurance System" can guarantee what the term implies. (None of these factors can assure quality by itself. In logical terms, all of the factors are necessary, but none are sufficient.) A different kind of monitoring can be conducted by parents and "significant others." According to the original article describing such a function, (Provencal, G. & Taylor, R. (1983). Security for parents: Monitoring of group homes by consumers. The Exceptional Parent, 13, p. 39-46. ... there is an important oversight role to be played by the "candid consumer. And when encouraged, this role can lead to improved programs which parents may come to trust more fully...Monitors do not visit homes where their relatives or wards reside...Visits are made approximately every 2 months...The monitor's primary responsibility is to evaluate the "feel" of each home; its appearance, atmosphere, warmth and overall sensitivity to...the resident's well-being. Quite deliberately, monitors do not assess individual client programs, procedure compliance, or performance toward standards that are to be reviewed by other agencies. (Conroy, Feinstein, and Lemonowicz, 1986)

#### **ICFs/MR Bed Decertification**

The statutory authority for a state plan for mental retardation services also requires that the plan include the number, type, and location of intermediate care beds targeted for decertification. Since ICF/MR bed use is now below 7,000 beds and the number of certified ICF/MR beds is rapidly decreasing, there is no need for involuntary bed decertification. However, continued voluntary decertification of beds is anticipated. In applying for renewal of the home and community-based services waiver, the Department is requesting 400 waiver "slots" (places) to enable several counties and residential services providers to accomplish service conversions which will make available to their residents smaller, more normal living arrangements.

The following is a summary of the voluntary conversions from ICFs/MR to waived services that are under negotiation between counties, providers and the Department of Human Services. While the following service conversions may not be achieved, other counties and facilities have contacted the Department to discuss service conversion of an additional 200 beds.

County	Provider	Number of People Served
Dodge	Woodvale Kassen	14
		46
Hennepin	Hammer Residences (Main Building)	73
Ramsey	Wicklough, Inc.	14
Stearns	St. Elizabeth	11
Winona	377 Main (Winona)	45
Wright	Madden Haven South	
		202

In addition, federal "look-behind" surveys and state licensing actions are anticipated to require the capacity for some involuntary conversions. At the time of the legislative moratorium on ICFs/MR development, concern was expressed that the moratorium would be a problem in meeting the terms of the consent decree, however, a February 1986 follow-up report by the Program Evaluation Division, Office of the Legislative Auditor, entitled "Deinstitutionalization of Mentally Retarded People," expressed the following opinion: 1) there was...no evidence that this moratorium has adversely affected compliance with the population reduction requirements of the (Welsch v. Gardebring) decree; indeed, the Department is likely to meet the consent decree's 1987 population reduction deadline with little difficulty. The 1988-89 biennium budget projects a reduction of 240 persons from regional treatment centers and corresponding reduction in certified beds.

#### **D. Expanding Community Capacity for People with the Most Severe Disabilities**

Historically, Minnesota and other states moved the most capable people back to their home communities first, leaving more severely handicapped people in inappropriate settings far from their homes.

While it has been well documented that virtually all children and adults with developmental disabilities, even those with high levels of physical or behavioral disabilities, can be served in ordinary homes if they are given adequate supports, it is equally true that we have developed an extensive network of ICFs/MR in Minnesota. Until the resources are available to do individualized residential placements for all children and adults, with size of residence not dependent on existing buildings, the Department will work with counties and community ICFs/MR to assist with physical plant and/or staffing modifications so that small ICFs/MR can assist with meeting the needs of all persons, even those with more severe disabilities, in order for such persons to live in settings that are more normal than those in which they currently reside.

#### **E. Home and Community-Based Waiver**

This program has been very successful in reducing both Minnesota's high utilization of ICFs/MR and the need for new ICF/MR development. Continued efforts are necessary in this program, however, to assist counties in: (1) reducing reliance on group home models by encouraging alternatives such as family foster care and in-home support services;

(2) assuring effective local administration and payment to county agencies for services; (3) assuring appropriate and effective cost control procedures for service expenditures; (4) assuring that services are provided as authorized in the individual service plans and contracts and are effective in achieving desired client outcomes; and (5) assuring that supported employment initiatives are supported to enable client integration and development of greater independence in normalized work settings.

The Department will submit a request for renewal of the Title XIX Medicaid Home and Community-Based Services waiver to the federal government prior to April 1, 1987. The home and community-based waiver will be re-submitted and will expand services by 960 persons.

#### **F. Community Services Technical Assistance**

The Department will assist counties and service providers in areas such as case management, assessment, service planning, quality assurance, contracting, and cost effectiveness. The Department will provide intensive assistance through a network of regional services specialists, central office staff and information dissemination. Emphasis will be placed upon assisting counties with individual service planning, developing individualized cost estimates and assuring service quality.

#### **G. Nursing Homes**

In August, 1986, the Department received instruction from the federal Health Care Financing Administration regarding inappropriate placement of persons with mental retardation or related conditions in skilled nursing facilities (SNFs) and intermediate care facilities (ICFs). These instructions stated, in part:

"...If the primary need of a mentally retarded person is active treatment for his/her retardation, then the person should be placed in an ICF/MR. ...Only a small percentage of mentally retarded persons would appropriately be placed in SNFs ... A patient well enough to attend outside training would nearly always be well enough to be placed in an ICF/MR or other appropriate setting... Providers should be aware that failure to comply with the above mentioned regulation governing the appropriate placement of mentally retarded persons in SNFs and ICFs could affect Federal reimbursement... inappropriate placement may also jeopardize the 'approved' status of a state plan." (HCFA Transmittal No. 19, August, 1986)

In 1985, there were 1,221 persons with a diagnosis of mental retardation residing in nursing homes, 537 persons in ICF-1 and 685 in skilled nursing levels of care. Of these 1,221 persons, 379 persons were under 65 years of age, 181 persons receiving ICF-1 level of care

and 298 persons receiving SNF level of care. Moreover, community DACs reported that 185 of their participants resided in a nursing home.

As a result of the instructions from HCFA, the Department has established special screening procedures for a person with mental retardation being recommended for placement into a nursing home or a resident in a nursing home, to prevent or identify inappropriate placements. The Department has requested additional funds to make available the appropriate alternative community services for persons identified as inappropriately placed in nursing homes.

#### **H. Supported Employment**

Madeleine C. Will, Assistant Secretary of the Office of Special Education and Rehabilitative Services recently wrote that:

The development of viable supported employment programs is slowly replacing institutionalization and day activity programs as the method of choice in dealing with individuals with disabilities. As we envision it, supported employment combines the ongoing support typically provided in day activity programs with paid work opportunities. Such supported employment programs could occur in a variety of settings: in dispersed individual placements in a community, with publicly funded support staff rotating among sites; or in a mobile crew working in neighborhood settings; or in group placements, with many individuals hired as a team, supervised directly by a job coach. (Will, 1986)

The Department will continue to assist habilitation and training services such as developmental achievement centers in their move toward real work alternatives through supported employment. By the end of the F.Y. 1988-89 biennium, 120 persons should be receiving supported employment services, and the Department will be working with federal agencies to meet new standards which fund such services under Title XIX.

#### **I. Division for Developmental Disabilities**

With the addition of related conditions to the Division's responsibilities, and in keeping with similar actions taken in other states and at the federal level, the Department will request passage of legislation to change the name of the division to Division for Developmental Disabilities.

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COUNTY	COUNTY UTILIZATION OF STATE REGIONAL CENTERS WELSH V. LEVINE TARGET AS OF JUNE 30, 1988				
	Utilization on 6/30/88	Utilization on 6/30/80	Net Reduction since 6/30/80	1987 Target	Reduction Needed by 6/30/87
1 Adair	8	10	2	9	0
2 Adoka	35	53	18	45	0
3 Becker	8	10	2	12	0
4 Beltrami	16	28	12	17	0
5 Benson	11	17	6	12	0
6 Big Lake	2	5	3	3	0
7 Blue Earth	35	54	19	30	5
8 Brown	22	35	13	19	3
9 Carlton	18	25	7	16	2
10 Carver	17	21	4	18	1
11 Cass	17	29	12	15	2
12 Chippewa	8	13	5	8	0
13 Chicago	4	7	3	6	0
14 Clay	22	32	10	22	0
15 Clearwater	2	2	0	2	0
16 Cook	3	2	-1	2	1
17 Cottonwood	2	13	11	8	0
18 Crow Wing	28	50	22	27	2
19 Dakota	43	62	19	52	0
20 Dodge	8	10	2	7	2
21 Douglas	17	26	9	18	1
22 Faribault (See Martin)	20				
23 Fillmore	8	23	15	12	0
24 Firestone	12	20	8	18	0
25 Goodhue	12	24	12	17	0
26 Grant	3	8	5	3	0
27 HENNEPIN	425	564	139	394	31
28 Houston	5	16	11	10	0
29 Hubbard	5	12	7	8	0
30 Itasca	1	9	8	8	0
31 Itasca	27	30	3	20	7
32 Jackson	5	6	1	5	0
33 Kanabec	5	6	1	5	0
34 Kandiyohi	12	14	2	12	0
35 Kittson	8	12	4	6	2
36 Knobloch	12	20	8	11	1
37 Lac qui Parle	4	7	3	5	0
38 Lake	8	15	7	9	0
39 Lake of the Woods	2	5	3	3	0
40 LeSueur	18	25	7	14	2
41 Lincoln (See Lyon)	4				
42 Lyon (Region VIII)	5	27	22	19	0
43 McLeod	11	20	9	14	0
44 Mahanomen	10	7	-3	4	6
45 Marshall	12	14	2	8	4
46 Martin (F&W)	8	62	54	32	0
47 Mower	11	15	4	10	1
48 Mills Lake	4	12	8	9	0
49 Morrison	15	38	23	19	0
50 Morse	29	41	12	23	6
51 Murray (See Lyon)	5				
52 Noland	12	12	0	11	1
53 Nolin	7	8	1	7	0
54 Norman	9	14	5	7	2
55 Olmsted	34	57	23	42	8
56 Otter Tail	39	53	14	20	9
57 Pennington	5	10	5	7	0
58 Pine	15	20	5	12	3
59 Pipestone	8	7	-1	5	3
60 Polk	15	27	12	20	0
61 Pope	10	12	2	7	3
62 RAMSEY	224	306	82	203	21
63 Red Lake	12	13	1	6	6
64 Redwood	8	18	10	10	0
65 Renelle	5	11	6	9	0
66 Rice	20	41	21	25	5
67 Rock	4	6	2	5	0
68 Roseau	11	18	7	10	8
69 ST. LOUIS	106	146	40	88	18
70 Scott	18	22	4	18	0
71 Sherburne	11	12	1	11	0
72 Shelby	15	15	0	8	7
73 Stearns	32	62	30	47	5
74 Steele	5	12	7	12	0
75 Stevens	4	8	4	6	0
76 Swift	5	7	2	6	0
77 Todd	15	38	23	18	0
78 Traverse	3	6	3	3	0
79 Wadena	13	21	8	12	1
80 Wadena	4	18	14	9	0
81 Wadena	5	13	8	9	0
82 Washington	20	27	7	22	2
83 Wauzeka (See Martin)	7				
84 Wilkin	11	14	3	7	4
85 Winona	19	30	11	20	0
86 Wright	11	14	3	12	0
87 Yellow Medicine	7	12	5	7	0
TOTALS	1,818	2,710	926	1,792	181



**Minnesota Department of Public Welfare**

**Six Year Plan of Action, 1981-1987**

**and**

**Biennial Budget Request, 1982-1983**

**for Mental Retardation Services**

MINNESOTA DEPARTMENT OF PUBLIC WELFARE  
SIX YEAR PLAN OF ACTION, 1981 - 1987  
and  
BIENNIAL BUDGET REQUEST, 1982-1983  
for MENTAL RETARDATION SERVICES

prepared by the  
Mental Retardation Program Division  
January, 1981

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MINNESOTA DEPARTMENT OF PUBLIC WELFARE  
SIX YEAR PLAN OF ACTION, 1981-1987 FOR  
MENTAL RETARDATION SERVICES

This is the Department of Public Welfare's six year plan for the development and provision of residential and day program services for mentally retarded people in Minnesota.

The plan has as its major goal, and as the goal that structures its specific provisions and target numbers, the deliberate and systematic reduction of the number of mentally retarded people living in the state hospitals to not more than 1,850 by June 30, 1987; and the simultaneous development of sufficient and appropriate community-based residential and day program services, in a manner that is as cost efficient and program effective as possible.

Several objectives are detailed in this plan to implement that goal.

BRIEF HISTORICAL PERSPECTIVE

Most of the substantive elements of this six year plan had their genesis in three sources: a Department examination of the proper role and functions of the state hospitals, the settlement of a class action suit (Welsch vs. Noot) by a consent decree, and interdepartmental state agency negotiations.

Department Examination

An advisory council was appointed in early 1979 by then-Commissioner Dirkswager to examine the total residential service system for mentally ill, mentally retarded, and chemically dependent citizens of Minnesota. Concurrently, the Mental Retardation Program Division met over several months with a task force of state hospital chief executive officers and their mental retardation program directors, considering the mentally retarded population that could best be served in the hospitals.

The products of these two efforts were summarized in the Commissioner's Instructional Bulletin 79-30 in June, 1979 and in the Residential Care Study and proposal presented by Commissioner Noot to Governor Quie in August of that year.

The documents proposed the numbers of mentally retarded people to be served in the state hospitals, the program services to be offered, and the development of community resources in terms that are very close to those of this six year plan.

Consent Decree

A class action suit of some seven year's development, initially Welsch vs. Likin, then Welsch vs. Dirkswager, and finally Welsch vs. Noot, was settled by a negotiated consent decree on September 15» 1980. The suit had been brought against the Commissioner on behalf of a class of mentally retarded

state hospital residents, and the consent decree applied the agreement to the entire state hospital system in its relationship to mentally retarded people.

The consent decree committed the state to a systematic reduction of the number of mentally retarded people to be served in the state hospitals, to a number of program improvements within the hospitals, to certain relationships between service in the hospitals and in the communities, and to the provision of support and technical functions. The decree also stipulated that certain legislative proposals would be made by the Department.

The Department determined that the stipulations of the decree were in very close agreement with the provisions of its own plan, and that the decreed program was within the Department's present organization, laws (with the changes proposed herein), and rule structure. This six year plan now reflects the agreements of the decree and of the legislative proposals.

#### Interdepartmental Negotiations

An interdepartmental cooperative stance has for many years characterized the relationship between the Department of Public Welfare and the Division of Vocational Rehabilitation in the Department of Economic Security.

Those portions of this plan that relate to work activity and sheltered employment are the result of negotiations with the Division of Vocational Rehabilitation. The plan will be noted to support the legislative requests of the rehabilitation division as an integral part of the system of day programs that serve mentally retarded people, and as a part that is essential to attaining the goal of this plan.

#### SYSTEM OF SERVICES IN MINNESOTA

Minnesota has a basically sound system of services to mentally retarded people, and one that requires no major change of direction from what has been emplaced over the past two decades. The system, not all of which is yet adequate in amount and development, is diagrammed below. The shaded areas are within the responsibility of the Department of Public Welfare.

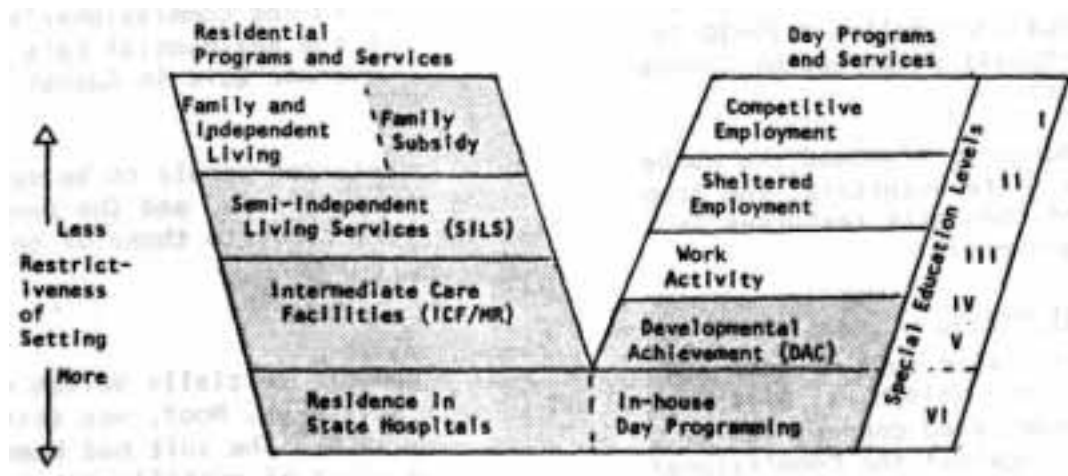


Figure 1

Continuums of residential and day programming used by mentally retarded people in Minnesota.

The diagram on the preceding page shows several important characteristics of the service system. The shaded portion, which is the responsibility of the Department of Public Welfare, is substantial. Equally important is the fact that other essential portions are the responsibility of other state agencies: special education, of the Department of Education; and work activity and sheltered employment, of the Division of Vocational Rehabilitation in the Department of Economic Security. It is crucial that the movement of mentally retarded people upward in the diagram, into less restrictive settings, be enabled by making available enough slots in the intervening steps so that the movement can take place.

As is indicated by the diagram, an in-hospital residential program generally implies an in-house day program. The correspondence at higher levels is not so precise. Similarly, the less restrictive levels of service are generally but not precisely less costly to the state.

#### GUIDING PRINCIPLES

The plan of action given here is guided by endorsement of these seven principles:

1. People who are mentally retarded or otherwise developmentally disabled can learn skills that can reduce their dependency and increase their self-sufficiency (This is the assertion of what is called "the developmental model.")
2. Reduction of dependency and increase in self-sufficiency in these people requires the availability of services that meet individual needs. (This asserts individual programming.)
3. Services to these people should be provided in environments that not only meet individual needs, but that are as little restrictive as is consistent with effectiveness. (This is the principle of least restrictive setting.)
4. The service environment, individual programs, and services to people who are mentally retarded or otherwise developmentally disabled should include patterns and conditions of normal, everyday life to the extent that the person's characteristics and service needs will allow. (This is the principle of normalization.)
5. The participation of the person in need of service, and of the family, are vitally important to the planning and provision of services. This implies an assurance that the services will be provided as close to the person's family and home community as possible.
6. The process of planning and service development is most effective when it reflects the needs and priorities of local units of service planning and administration. This must be set in the context of a systematic analysis of all services necessary and of all roles necessary in a total service system.
7. Case management by the local social service agency for all individuals needing social service, and local planning and coordination of services among the mental health and human service agencies, are vital components of the service system.

## CURRENT (1980) STATUS OF MINNESOTA

The numbers and circumstances described in this section are those of 1980, the most current period for which they may be cited.

### State Hospitals

There are approximately (2,650) mentally retarded people living in and receiving day program services in Minnesota's eight state hospitals. By June 30, 1981, the number is expected to be 2,600; by June 30, 1987, this number will be reduced to 1,850. Occupancy rates vary with each hospital, and only two (they are Cambridge and Faribault) serve mentally retarded people exclusively. A substantial number of these people have been determined to be capable of being served in community-based intermediate care facilities for the mentally retarded (ICF/MRs) if those services and their accompanying day programs were available.

The costs and cost distribution of state hospital service, and of the other services described in this section of the plan, will be found in Table 1.

### Community Residential Facilities (CRFs) for the Mentally Retarded

People who live in CRFs number just under 4,000 of these, approximately 400 have been determined to be ready for and in need of Semi -Independent Living Services but, as will be noted, the services are not available in that amount.

Of the 4,100 CRF residents, about 3,000 are in Intermediate Care Facilities for the Mentally Retarded (ICF/MRs), Medicaid recipients under Title XIX of the Social Security Act. Approximately (60% of the ICF/MR residents, who are adults, attend developmental achievement centers (DACs), with most of the rest being in schools, work activity programs, or sheltered employment or other sheltered workshop services. The CRFs also house about 700 of the 1,250 children who are funded under Cost of care support. The CRF occupancy rate is about 94%, with vacancies being due to down time in turnover or resident movement.

Table 1 shows separate columns for ICF/MR and Cost of Care community residence programs, because the funding differs.

### Semi-Independent Living Services (SILS)

The functional equivalent of this service is being currently provided to about 180 mentally retarded people, most of whom live in board and lodging circumstances funded under Minnesota Supplemental Assistance (MSA), Social Security benefits, and sometimes their own earnings. Most of the semi-independent living services themselves are funded through Purchase of Service contracts by the county of responsibility, ultimately paid under Title XX of the Social Security Act, county dollars, and DPW Rule 23 grants.

The average length of stay of a mentally retarded client in semi-independent living service has been 1.4 years, verifying that the service is actually serving a transitional purpose. Movement has been into fully independent living. "Occupancy" rate in SILS is 100%, with a waiting list.

Table 1 shows separate columns for the two components of SILS, the residential and the service components. The reported cost for board and lodging may be an overestimate, because Social Security benefits and client earnings have not been computed.

Table 1

Summary of costs and sources of funding for the major residential and day programs for mentally retarded, people in Minnesota; actual or estimated figures for FISCAL YEAR 1980.

	Self- contained state hosp	Community Residential				Service SILS (service)	DAC Programs		Vocat' Wk Act, Sh Emp
		ICF/MR	Cost of Care	Family Subsidy	SILS (resid)		Adult DAC	Child DAC	
Annual Budget (in thousands)	68,314	39,766	7,900	275	564	565	13,300	6,700	11,550
Number of Retarded People Served	2,692	3,700	Children: 650	105	180	180	3,600	1,400	4,200
Average Daily Cost per Person	\$71.00	\$39.00	\$49.79	\$ 7.33	\$ 8.40	\$11.64	\$22.00	\$32.50	\$ 7.53
Percent Paid by Federal Share	55.64%	55.64%	0.0%	0.0%	0.0%	0.0%	26.3%	26.3%	0.0%
Percent Paid by State Share	44.36%	39.92%	53.7%*	100%	50.0%	***	22.4%	22.4%	43.8%
Percent Paid by County Share	0.0%	4.44%	30.39%*	0.0%	50.0%	***	45.3%	45.3%	3.0%
Percent Paid through Other Sources	0.0%	0.0%	16.0%*	**	**	0.0%	4.4%	**	53.2%

NOTE: all the foregoing are for Fiscal Year 1980.

\* = reflects the state, county, and third party payments of GROSS eligible costs for the Cost of Care program; the shares for NET eligible costs were -- state, 63.5%, and county, 36.5%.

\*\* = this is an unknown and unaccounted amount; for example, family or agency in-kind contribution.

\*\*\* = each county currently funds "SILS" in a different manner; some using state funds allocated in CSSA or under Rule 23 deinstitutionalization funds, others using only county dollars.



### Family Subsidy

In fiscal 1980, 105 families in Minnesota received an average of \$220 per month in grants to provide services that encouraged them to keep at home the mentally retarded children who might otherwise require state hospital or other out-of-home placement. This program is of sufficient national interest that it is now being studied by other states as a possible model. There is an active waiting list, and there has always been a much larger demand for the service than could be provided with available funding.

In this plan, the Family Subsidy program is proposed for change from an experimental designation to status as an established program.

### Developmental Achievement Centers (DACs)

Participants in this service currently number over 5,000, of whom 3,800 are adults. About 60% or 2,300 of these adults live in ICF/MRs, and most of the others live in their natural, adoptive, or foster homes. Over 500 DAC participants have been identified as ready for and in need of movement into work activity or into sheltered employment if space were available. The DAC occupancy rate is essentially 100%.

It should be noted, in Table 1, that the DAC cost figures represent the federal, state, and county cost sharing that prevails under the Community Social Services Act (CSSA). which became effective on January 1, 1980.

### Work Activity and Sheltered Employment

These services are located in work activity centers and in sheltered workshops (occasionally, on an individual basis, sheltered employment may be stationed in private industry), under the responsibility of the Division of Vocational Rehabilitation in the Department of Economic Security. There are approximately 4,200 people, the majority of whom are mentally retarded, in work activity and in sheltered employment in 28 facilities in Minnesota. Movement from these stations into competitive employment is estimated to be 200 people per year. The centers and shops have 100% occupancy rates.

Work activity and sheltered employment are important to the six year plan of the Department of Public Welfare because they are an essential part of the upward mobility of mentally retarded people, especially of those who are ready to leave DAC service.

### Summary of Status

Several capacity constraints, it will have been noted, impede the movement of mentally retarded people into less restrictive and less costly programs in both the residential and day segments.

The objectives and action proposals of this six year plan, and the proposals for the 1982-1983 biennium, are designed to enable service to more mentally retarded people to be given in the less restrictive (and generally less costly) programs, moving them out of the more restrictive (and generally more costly) programs. For that movement to take place, each succeeding level must have enough capacity to accommodate both the long-term clients and those who are moving through; else, mobility is impeded or halted.

The relative costs of the levels of programming may be illustrated. The daily cost for a combination of residential and day program in 1980 was (see Table 1) approximately: state hospital self-contained program, \$71.00; community-based ICF/MR residence plus DAC day program, \$61.00; SILS residence plus SILS service plus DAC day program, \$27.57. These are, of course, averages rather than specific cases.

#### GOAL OF THE PLAN, RECAPPED

The goal of this six year plan is a single goal because the service system is a single fabric. However, it addresses two main arenas: the state hospital system, and the community service system. The goal, it will be recalled, is

"the deliberate and systematic reduction in the number of mentally retarded people living in the state hospitals to not more than 1,850 by June 30, 1987; and the simultaneous development of sufficient and appropriate community-based residential and day program services, in a manner that is as cost efficient and program effective as possible.

In addition to residential and day programs, the community-based system must naturally include those support services that will enable its effective function.

From this goal, ten objectives for the six years have been derived. The first of them is explicit in the goal statement and the others are implicit. Those ten objectives, and the means for attaining them, follow.

#### OBJECTIVES

OBJECTIVE ONE: To reduce the net number of mentally retarded state hospital residents on a mandated schedule to 1,850 by June 30, 1987.

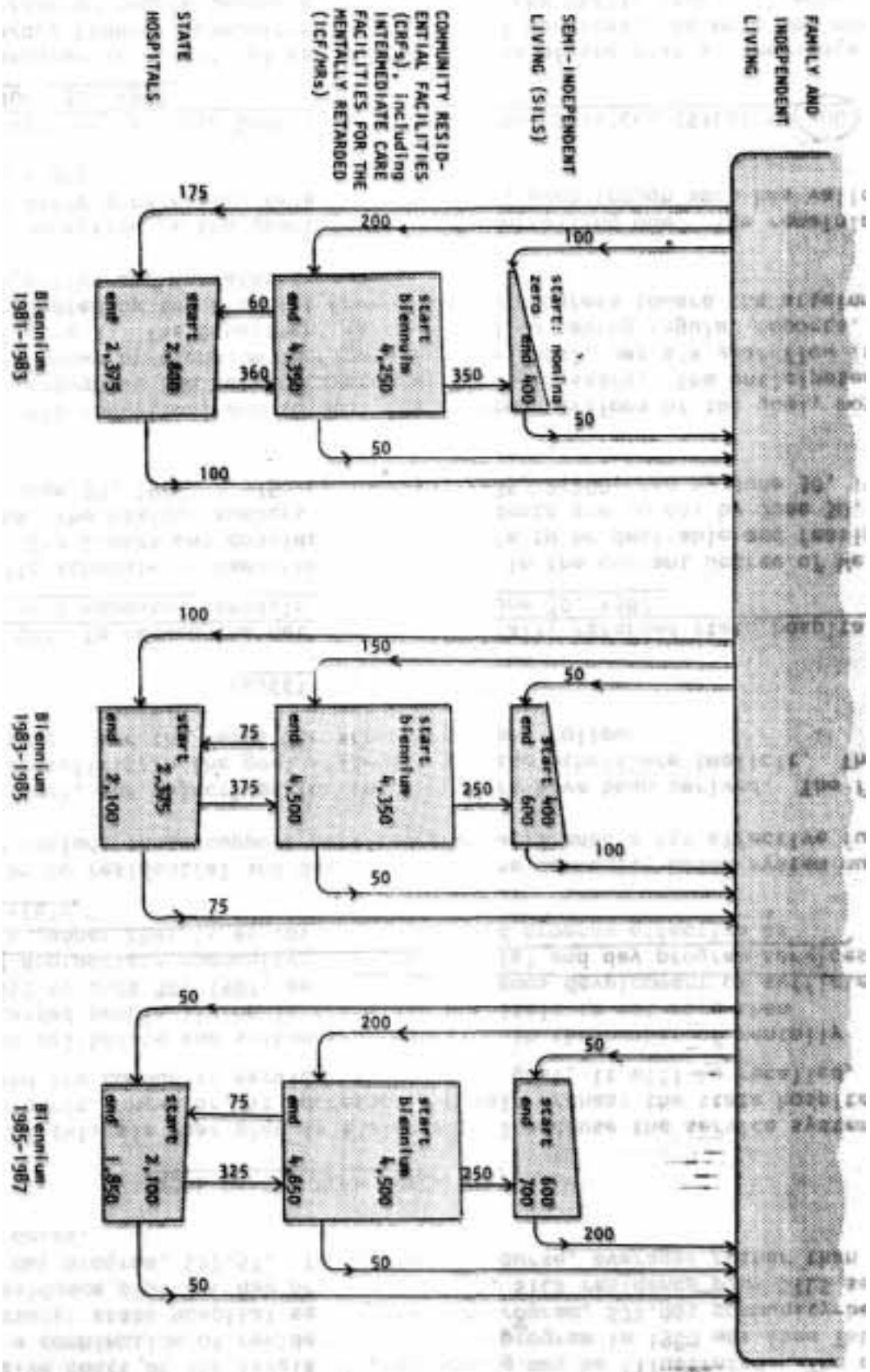
The specific schedule of reduction is mandated in the consent decree of Welsch vs. Noot. The Department considers the schedule to be desirable and feasible. By biennium, the maximum numbers of these residents are to be: by June 30, 1981, 2,600; by June 30, 1983, 2,375; by June 30, 1985, 2,100; and by June 30, 1987, 1,850.

To enable this reduction, and to meet the related portions of the goal, movement of people throughout the service system will be necessary. The anticipated movement is shown by biennium in Figure 2. The total, net six year flow is shown in Figure 3. The Department is committed to making regular reports, to a monitor appointed by the District Court, on its progress toward the attainment of this objective and on related matters.

This first objective is the quantitative and controlling one. The remaining objectives carry a necessary relationship to it, even though each has validity in its own right.

OBJECTIVE TWO: To increase Semi-Independent Living Services (SILS) to 700 slots by June 30, 1987.

The SILS program is a critical key to the success of the plan as the state moves toward a broader community-based system of services. As more and more mentally retarded people become ready to master the skills that will enable them to function in a more independent manner, the settings and services that



\*

Figure 2 Anticipated residential movement during the six years of the plan; by biennium.

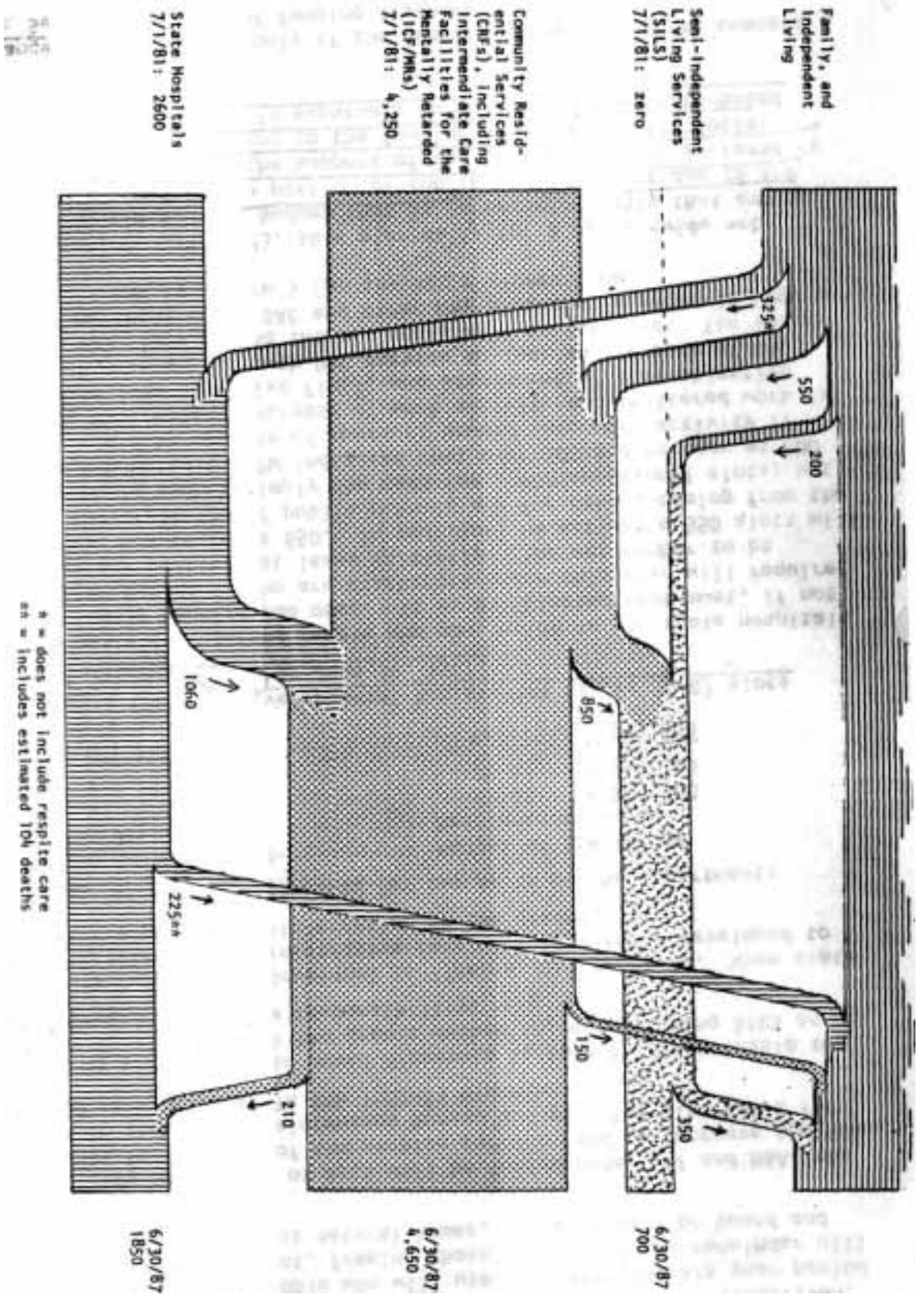


Figure 3  
Anticipated residential movement of mentally retarded people during the six years covered by the plan.

will equip them with those skills must be made available. On its present informal record, the SILS program does enable them to make this transition. Most of the estimated 1050 people who will use SILS over the six year period will come from ICF/MR placement, freeing those slots, and the remainder will come from other sources such as natural homes, foster homes, or board and lodging facilities.

The board and lodging portion of SILS will be funded under SSI and MSA; the proposal here is for funding of the service portion, and to increase the MSA appropriation in the Income Maintenance Bureau budget. The plan calls for developing 400 service slots in the 1982-83 biennium.

Statutory change proposed is to amend Minnesota Statute § 252 to enable the administration of SILS through the grants mechanism, establishing SILS as an experimental program under DPW responsibility.

Rule change; DPW Rule 18 was developed to license SILS programs. When state funding is authorized, an administrative rule will have to be developed to cover the disbursement and administration of the grants.

Biennial budget for SILS is requested for two units of the Department:

budget of the Mental Retard- ation Program Division		budget of the Income Maintenance Bureau	
FY 82	\$ 425,000	FY 82	\$ 249,900
FY 83	\$ 1,275,000	FY 83	\$ 749,100
Total	\$ 1,700,000	Total	\$ 999,000

OBJECTIVE THREE: To increase Developmental Achievement Center (DAC) slots from the present 5,000 to 5,800 by June 30, 1987.

In general, the mentally retarded people who now reside in the state hospitals are the more seriously handicapped ones. It is anticipated that most, if not all, state hospital residents who are discharged under this plan will require DAC placement for day service, at least initially. The net number to be discharged in these six years is 850. In addition, an estimated 550 slots will be required for the graduates of public schools and for others coming from the community. This would seem to imply the need for 1,400 additional slots; but a 1978 DAC study conducted by DPW indicated that over 500 and as many as 600 DAC participants would be capable of movement upward into work activity if such service were available. Increase of work activity and sheltered work is a part of this plan (see Objective Five), and attainment of that objective will enable enough movement through DAC service so that an increase of DAC capacity by only 800 slots during the six years will be required. The inter-relationships of movement among DAC and other day programs is shown in Figure 4 on a biennial basis and in Figure 5 for the net six-year flow.

For the first biennium, 1981 - 1983, this plan calls for a system-wide net increase of 200 DAC slots. The budget that is requested is only that amount that is needed to accommodate the portion of the increase that is due to the releases from state hospitals; the support of the rest of the DAC increase is separately proposed as an addition to the funding of the Community Social Services Act appropriation that is eventuate in support of community-based demands.\_

Statutory change will be needed only if the funding formula is to be changed. See Objective Seven on removal of funding disincentives.

Rule change is not required. However, if the funding formula is changed, DPW Rules 52 and 31 will need to reflect this.

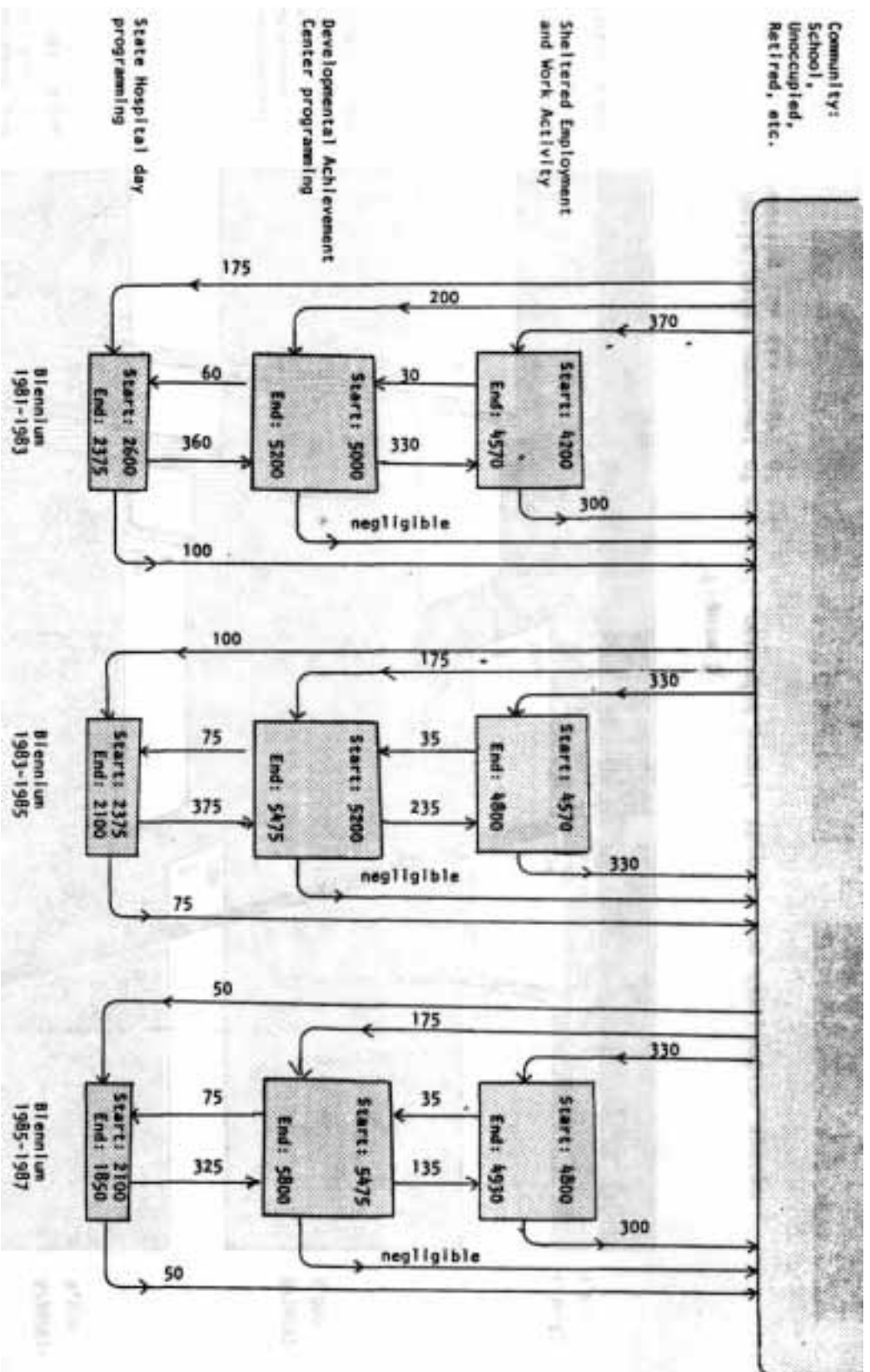


Figure 4  
Anticipated movement of mentally retarded people in day programs during the six years of the plan; by biennium.

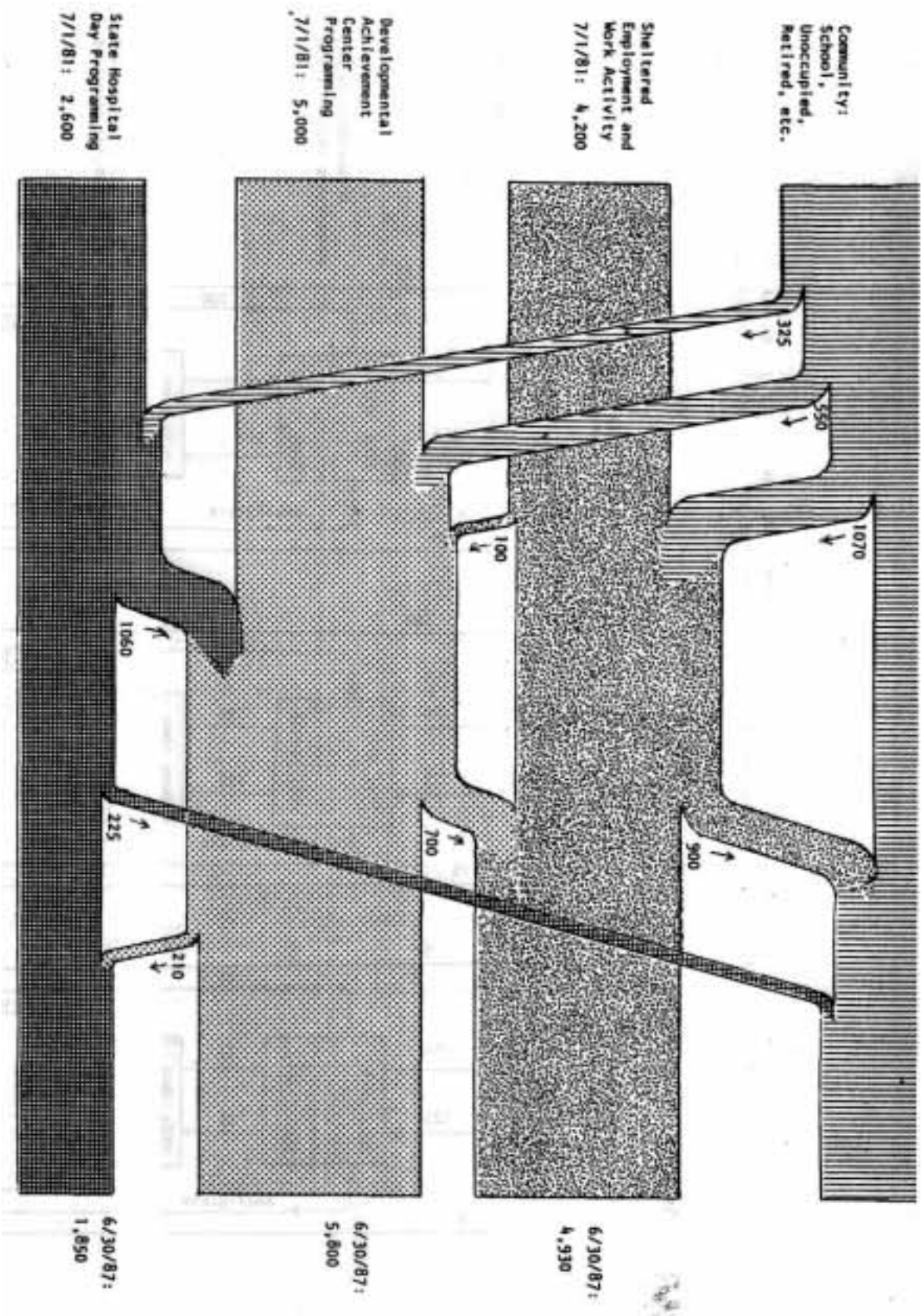


Figure 5  
Anticipated movement of mentally retarded people through the day program system during the six years of the plan.

Biennial budget for DACs is, in the amount given here, requested to cover an additional 50 lots in each year of the biennium to accommodate state hospital releases. An additional increase to be found in the CSSA budget request is expected to accommodate a projected additional 100 clients from the community. The request here is for

FY 82	\$ 82,250
FY 83	\$ 268,700
Total	<u>\$ 350,950</u>

OBJECTIVE FOUR: To develop 400 additional ICF/MR beds in the community by June 30, 1987.

A net reduction of approximately 800 in the number of mentally retarded people in state hospitals will require that new community-based residential placements be made available. The people who will be released are typically more seriously handicapped than are those who are already in the community and they will, in nearly all instances, need ICF/MR placement. Many of them are expected to replace people who will move into Semi-Independent Living Services; see Objective Two, and Figures 2 and 3. Consequently, the necessary expansion of ICF/MR capacity will be 400 rather than 800. Many of the current ICF/MR programs will need modification in order to properly serve the more seriously handicapped state hospital releases, and some additional types of ICF/MR must be developed.

This plan calls for an additional 100 ICF/MR beds this biennium. Fifty will be for children funded under Cost of Care. and 50 will be adults.

Statutory change is not needed.

Rule change is not proposed. The need determination procedures and criteria have been included in DPW Rule 185, revised in 1980.

Biennial budget requested here does not include coverage of the 50 adult beds, since that is already included in the Medical Assistance forecast. The Cost of Care increase for the 50 children is.

FY 82	\$ 66,950
FY 83	<u>\$ 200,800</u>
Total	\$ 2677750

OBJECTIVE FIVE: To develop an additional 600 work activity and sheltered employment stations by June 30, 1987.

These stations are provided under funding and regulation of the Division of Vocational Rehabilitation in the Department of Economic Security. They represent levels of occupation, at some wage, above that of DACs (see Objective Three), and they are a critical statewide need to provide higher levels of development for those DAC participants who are ready for this upward movement.

It is estimated that movement of DAC participants into work activity and sheltered employment, together with movement of others into competitive employment, will enable the 600 work activity and sheltered employment stations to serve 950 individuals over the six years of the plan. The Department agrees with the Division of Vocational Rehabilitation that 300 stations will need to be added to this critical link in the day program chain during this first biennium.

Statutory change. is not needed



Rule change regarding work activity and sheltered employment, if any, would be under the responsibility of the Division of Vocational Rehabilitation.

Biennial budget for this would be in that of the Division of Vocational Rehabilitation. The Department strongly supports that agency's request of

FY 82	\$ 505,500
FY 83	\$ 743,100
Total	\$ <u>1,248,600</u>

OBJECTIVE SIX: To increase the Family Subsidy program to serve a total of 200 families by June 30, 1983.

This program has grown from 50 families in 1978 to 105 in 1980. A study of applications indicates a need to serve at least 200 families. This program has assisted families to keep their mentally retarded children at home and it thereby reduces or postpones placement in ICF/MRs and state hospitals. It is an early intervention service that enables living in the least restrictive and most normal setting, at minimal cost to the state. The Department recommends this program as a mechanism under the Welsch vs. Noot consent decree, and as an alternative to out-of-home placement.

The request here is for funding to add 45 new families in FY 82 and 50 more families in FY 83

Statutory change recommended is to amend Minnesota Statute § 252.27 to make this an established rather than an experimental program.

Rule change needed is that which would bring language into conformity to the statutory amendment.

Biennial budget requested here is

FY 82	\$ 123,200
FY 83	\$ 250,800
Total	\$ <u>374,000</u>

OBJECTIVE SEVEN: To increase construction grants-in-aid for establishment of community residential programs.

Amendment to Minnesota Statute § 252.30 was authorized by the 1980 Legislature to allow grants to new residential facilities to pay reimbursable start-up costs until payment for services can begin. This program has played a significant part in the development of community facilities. The planned expansion provides an increase to meet the need expected to arise from both numbers and kinds of state hospital discharges.

Until now, very little of this program has been used for remodeling community facilities. With the movement into the community of more seriously handicapped residents, and with the movement into Semi-Independent Living of the less seriously handicapped, some vacancies in existing facilities will require remodeling to accommodate physical, sensory, and behavioral disabilities. Like the creation of a new service, remodeling is reimbursable under ICF/MR rates, but up-front money is needed to prevent delay in admitting referrals from the state hospitals.

The Minnesota Housing Finance Agency is expected to increase loans for new facilities, including facilities for the physically handicapped. This will cause DPW to face increased demand for start-up and remodeling grants. Because of anticipated change in need and pay-back provision, this plan may call for amendment to statute to allow a revolving account for both profit and non-profit organizations. A feasibility study is to be done by September, 1981. The biennial budget below is requested to start up seven to eight new facilities.

Statutory change to Minnesota Statute § 252.30 may be recommended so as to authorize grants to profit and non-profit service providers for: construction grants-in-aid; grants for reimbursable start-up costs, to be repaid; and remodeling of existing facilities to accommodate more handicapped residents.

Rule change will be needed in DPW Rule 37 if the statute is amended.

Biennial budget requested here is for the increase only:

FY 82	\$ 122,600
FY 83	\$ 122,600
Total	<u>\$ 254,200</u>

OBJECTIVE EIGHT: To remove fiscal disincentives for counties to place mentally retarded people in community-based facilities and programs rather than in state hospitals.

A major potential barrier to reaching the goal of this plan is the fact that it costs the counties substantially more money to serve mentally retarded people in the community than in state hospitals. At present, counties are not required to pay for the care of their citizens who are state hospital patients covered by medical assistance, and they are required to pay only \$10 per month for the care of those who are not eligible for medical assistance. It costs the counties a significant amount to care for such people in community-based services.

The general direction of DPW legislative proposals is to re-channel state funds in such a way as to encourage the development and use of community-based services. In addition to the negligible cost to counties of state hospital care, a major disincentive has been inadequate state funding to other portions of the continuum of care. To alleviate these fiscal disincentives to sound case service, the Department is proposing legislation that will, on the one hand, require counties to pay more toward the cost of care in state institutions, and on the other will increase financial assistance to counties for the care of mentally retarded people in the community. All of the requests detailed in this plan can be viewed as the Department's overall effort to meet this objective.

Statutory change has been recommended to amend Minnesota Statute § 245.0313, obligating county payment for state hospital care in equal proportion as is provided in Minnesota Statute § 256E.19 for community residential care.

Rule change may be required in several DPW rules, depending upon legislative action upon proposed bills that are before this session.

Biennial budget increases relating to this objective are summarized in Table 2 by amounts, sources, and location in the state budget.

OBJECTIVE NINE: To provide technical assistance to counties and to providers and developers of community-based services.

This objective is designed to enable DPW central office capability to implement this six year plan as its objectives affect counties, providers of service, and developers of new services. Three new technical assistance specialist (TAS) positions will provide technical assistance: in county planning, placement, and case management; to development and utilization of community-based services and facilities; to coordination of efforts among state hospitals, community residential facilities and support services, DACs, sheltered workshops and work activity centers; and to the resolution of service and coordination problems at the local level as needed by the agencies involved.

This objective is additional to the present and ongoing work of the Department, in that it requires three set-aside positions, although it is within the existing scope of the Department's mission and functions.

Statutory change is not required.

Rule change is not required.

Biennial budget is to be absorbed within the existing DPW budget; no increase requested here.

OBJECTIVE TEN: To fully implement a statewide caseload management information system to monitor the status and progress of all mentally retarded clients who are the responsibility of DPW.

The Minnesota Developmental Programming System - Case Management Battery (MDPS-CMB) is DPW's individual case management document. It satisfies county case reporting requirements and generates information for the CSSA purposes of planning, evaluation, and tracking. It is also the primary behavioral assessment instrument used by community-based programs and by county case managers, and is used for all state hospital residents. It is by means of this instrument that DPW will monitor client flow throughout the six year plan to deinstitutionalize 800 mentally retarded people. Some aspect of compliance with the Welsch vs. Noot consent decree will also be monitored with the aid of this system.

The MDPS-CMB document is generated in reference to each of the 14,000 clients who are the responsibility of the Mental Retardation Program Division of DPW because they are in services that are regulated by the Department. Individual profiles are thereby provided to the service providers who were involved in generating the document, and to the counties having case management responsibility. The status and characteristics are summarized for planning purposes at county and other levels as an integral part of the management information system.

Statutory change is not required.

Rule change is not required

Biennial budget requested for the operation of the system is

FY 82	\$ 90,000
FY 83	\$ 90,000
Total	<u>\$ 180,000</u>

## SUMMARY OF BIENNIAL BUDGET REQUESTS

Table 2 summarizes the FY 1982-83 budget requests by objective, amount, source, and location in the Department and other agency budgets.

### BUDGET COMPUTATION METHODOLOGIES

The methodologies and assumptions described in this section were used in computing the biennial budget requests of the plan. They are described here by objective.

#### OBJECTIVE TWO: Semi -Independent Living Services (SILS), service portion.

Welsch vs Noot demand for the biennium equals 300 slots. Projected community-generated demand equals 100 slots.

Note 1: Costs for services are projected at \$11.64 per day on the average, based upon the 1980 survey of existing SILS equivalent.

FY 82 200 projected new slots x \$11.64 x 365 days = \$ 424,860  
2 (for 50% average occupancy)

rounded: \$ 425,000 FY 82

FY 83 - 200 filled slots x \$11.64 x 365 days = \$ 849,720

200 new slots x \$11.64 x 365 days x 50% occ = \$ 424,860

sum: \$1,274,580

rounded: \$ 1,275,000 FY 83

SILS biennial request: \$ 1,700,000

Note 2: Subsequent to the development of budget request for inclusion in the Welsch vs. Noot consent decree, a bill was drafted authorizing the Commissioner of DPW to reimburse counties up to 90% of SILS cost. The cited cost of \$11.64/day was 1980 cost. If inflation rates of 9.1% for 1982 and 8.6% for 1983 are applied, the effect of the 90% provision is almost exactly canceled, leaving \$1,700,000 as the amount still estimated to be needed.

Table 2  
Budget summary, Department of Public Welfare plan, for the biennium  
1981-83; by objective.

OBJECTIVE	ADDED SLOTS		PROPOSED BUDGET BY YEAR OF BIENNIUM				PROPOSED BUDGET BY SOURCE		LOCATION OF BUDGET REQUEST
	FY82	FY83	FY82	FY83	TOTAL		STATE	COUNTY	
Objective Two: Semi-Independent Living Services	200	200	\$ 425,000	\$ 1,275,000	\$ 1,700,000		\$ 1,700,000	170,000	Mental Health Bureau Mental Retardation Progr Div
Minnesota Supple- mentary Assistance	150	150	\$ 294,000	\$ 882,000	\$ 1,176,000		\$ 999,000	\$ 177,000	Income Maintenance Bureau
Objective Three: Developmental Achievement Ctrs	50	50	\$ 164,500	\$ 537,400	\$ 701,900		\$ 350,950	\$ 350,950	CSSA budget Social Services Bureau
Objective Four: ICF/MR	25	25	---	---	---		---	---	Incorporated in projections for Medical Assistance
Cost of Care	25	25	\$ 133,900	\$ 401,600	\$ 535,500		\$ 267,750	\$ 267,750	CSSA budget Social Services Bureau
Objective Five: Work activity & Shelter Employment	150	150	\$ 505,500*	\$ 743,100*	\$ 1,248,600*		\$ 1,248,600*		Division of Vocational Rehab Department Economic Security
Objective Six: Family Subsidy	45	50	\$ 123,200	\$ 250,800	\$ 374,000		\$ 374,00		Mental Health Bureau Mental Retardation Progr Div
Objective Seven: Construction Grants-in-Aid	--	--	\$ 122,600	\$ 122,600	\$ 245,200		\$ 245,200		Mental Health Bureau Mental Retardation Progr Div
Objective Ten: Case Management Information System	--	--	\$ 90,000	\$ 90,000	\$ 180,000		\$ 180,000		Mental Health Bureau Mental Retardation Progr Div
TOTAL PROGRAM			\$1,858,700	\$4,301,500	\$6,161,200		\$5,365,500	\$965,700	

\* The cost figures for Objective Five were provided by the Division of Vocational Rehabilitation in the Department of Economic Security, and represent only the state support to this service; production, private contributions, etc. are not calculated.

The Department of Public Welfare is recommending an increase of over \$25,000,000 for county funding through the Community Social Services Act (CSSA). This increase is important if the Welsh vs Noot consent decree is to be met because it contains the state funds for: increased case management and planning effort at the local level; and accommodation of existing and expected increase of community-origination- demand for developmental achievement services and for cost of care programs for children.

OBJECTIVE TWO: SILS, Minnesota Supplemental Assistance portion.

Note 1: Projected cost from Income Maintenance Bureau of DPW is \$327 per client per month, or \$3,924 per client per year.

$$\begin{array}{lcl} \text{FY 82} & \text{--} & \frac{150 \text{ projected new clients} \times \$3,924 \text{ per year}}{2 \text{ (for 50\% average occupancy)}} = \$ 294,000 \text{ FY 82} \\ \text{FY 83} & \text{--} & 150 \text{ filled slots} \times \$3,924 \text{ annual cost} = \$ 588,000 \\ & & \frac{150 \text{ projected new slots} \times \$3,924 \text{ per year}}{2 \text{ (for 50\% average occupancy)}} = \$ 294,000 \\ & & \text{sum: } \$ 882,000 \text{ FY 83} \end{array}$$

MSA biennial request: \$ 1,176,000

Financial participation in MSA portion of SILS by source (\$thousands):

	State	Counties	Total
FY 82	249.9	44.1	294
FY 83	749.7	132.3	882
Biennium	<u>999.6</u> (85%)	<u>176.4</u> (15%)	<u>1,176</u>

OBJECTIVE THREE: Developmental Achievement Center (DAC) programs. +

Welsch vs Noot demand for the biennium equals 100 slots.

Note 1: Per diem cost estimates are based on a survey of DACs serving more seriously handicapped adults.

FY 81 \$ 28.20 per day  
FY 82 \$ 30.75 per day\*  
FY 83 \$ 33.48 per day\*

\* based upon Department of Finance projection of 9.1% inflation for FY 82 and 8.6% for FY 83.

Budget calculations:

$$\begin{array}{lcl} \text{FY 82} & \text{--} & \frac{50 \text{ est. new clients} \times \$30.75 \times 214 \text{ days}}{2 \text{ (50\% average occupancy)}} = \$ 164,500 \text{ FY 82} \\ \text{FY 83} & \text{--} & 50 \text{ existing clients} \times \$33.48 \times 214 \text{ days} = \$ 358,240 \\ & & \frac{50 \text{ new clients} \times \$33.48 \times 214 \text{ days}}{2 \text{ (50\% ave occupancy)}} = \$ 179,120 \\ & & \$ 537,360 \\ & & \text{rounded: } \$ 537,400 \text{ FY 83} \\ & & \text{Biennium: } \$ 701,900 \end{array}$$

Financial participation in DACs by source (\$thousands):

	State	Counties	Total
FY 82	82.25	82.25	164.5
FY 83	268.7	268.7	537.4
Biennium	<u>350.95</u> (50%)	<u>350.95</u> (50%)	<u>701.9</u>

OBJECTIVE FOUR: Cost of Care portion, Community Residential Facilities.

\* Weisch vs Noot demand is estimated to be 50 additional placement slots for the biennium.

Note 1: Average annual cost to the state and county is estimated to be \$10,712 per child. This is net cost, after payment of fees by third parties such as social security, parents, etc:

FY 82 ==	<u>25 additional children x \$10,712 annual</u> 2 (for 50% average occupancy)	= \$ 133,900 FY 82
FY 83 ==	25 existing children x \$10,712	= \$ 267,800
	<u>25 additional children x \$10,712 annual</u> 2 (for 50% average occupancy)	= \$ 133,900
		<u>\$ 401,700 FY 83</u>
	Biennium:	\$ 535,600

Financial participation in Cost of Care by source (\$thousands):

	State	Counties	Total
FY 82	66.95	66.95	133.9
FY 83	<u>200.85</u>	<u>200.85</u>	<u>401.7</u>
Total	267.8 (50%)	267.8 (50%)	535.6

OBJECTIVE FIVE: Work Activity and Sheltered Employment

Computations are in the budget of the Division of Vocational Rehabilitation, Department of Economic Security.

OBJECTIVE SIX: Family Subsidy program.

+ Welsch vs Noot demand is served by 45 additional families in FY 82, and 50 additional families in FY 83.

+ Average monthly grant per family has been \$220,

FY 82 -- 45 additional families x \$220 x 12 months = \$ 118,800 FY 82

FY 83 -- 95 families (beyond 1981) x \$220 x 12 = \$ 250,800 FY 83

Biennium: \$ 369,600 \*

Financial participation by source (\$thousands):

	State	Counties	Total
FY 82	118.8	--	118.8
FY 83	250.8	--	250.8
Biennium	<u>369.6</u>	<u>--</u>	<u>369.6*</u>

\* Negotiations on the consent decree led to stipulation to request a biennial increase of \$374,000, a difference of \$4,100 from the calculation given here.

OBJECTIVE SEVEN: Construction Grants-in-Aid.

+ The requested \$122,600 increase per year will bring the appropriation up to \$600,000 for the biennium. The basis for this figure is that it was negotiated by the Welsch vs Noot plaintiffs, the Department, and legislative staff.

FY 82 -- negotiated request FY 83 -- ' negotiated request

= \$ 122,600 FY 82

= \$ 122,600 FY 83

Biennium:

\$ 245,200

Financial participation by source (\$thousands):

	State	Counties	Total
F Y	8 2	1 2 2 . 6	122.6
F Y	8 3	<u>1 2 2 . 6</u>	<u>122.6</u>
Biennium		245.2	245.2



OBJECTIVE TEN: Case Management Battery.

Note 1: The \$90,000 per year estimate is based upon actual operating costs for the past three years, with adjustment for inflation and for increased utilization and system application.

FY 82 FY 83	= \$ 90,000 FY 82
	= \$ 90,000 FY 83
Biennium:	<u>\$ 180,000</u>

Financial participation by source (\$thousands):

	State	Counties	Total
F Y	8 2	9 0 . 0	90.0
F Y	8 3	<u>9 0 . 0</u>	90.
Biennium		180.0	0
			180.0

STATE OF MINNESOTA

DEPARTMENT of Public Welfare

## Office Memorandum

TO : **Advisory Council**

Date: September 16, 1982

FROM :

  
Ardo Wrobel

PHONE: -"296-2160

SUBJECT: Status Report - for Discussion in September 23 Meeting

Attached is the status report of the Mental Retardation Program Division which includes 1) priority areas for 1983-85 legislation, 2) areas specifically required under Welsch v. Noot and subsequent Court Orders, and 3) Commissioner's obligations to propose to the Governor for submission to the legislature measures necessary for implementation of the Consent Decree.

The status report on the program represents the views and perceptions of the MR Division staff. Your review and comment on this is requested, so that 1) a status report of the DPW Six Year Plan can be published for interested persons in state and county government, advocate groups and general public, 2) legislative and budget proposals can be considered by the Commissioner.

BTH/16

cc: Arthur E. Noot  
Kevin Kenney  
Ronald Young,  
M.D. Robert Baird  
Bev Driscoll  
Pat Gaylord  
Barb Stromer  
Lyle Wray  
Dennis Boland

## MAJOR PROBLEM AREAS

### Problem Area I

A. Statement: There has and continues to be developing a critical inadequacy of day developmental programs for residents of ICF/MR facilities in the community.

B. Goal to be attained:

"All ICF/MR residents will have a full-time (six hours/day, five days/week) day program of purposeful activity outside of their place of residence."

C. Reasons, related issues:

1. Title XX cutbacks and county budget problems have reduced the counties capability to maintain the level of DAC programming for existing ICF/MR residents, or, to expand day services to accommodate new ICF/MR residents.
2. Several counties have reduced DAC services to three days per week placing a staffing burden on ICF/MRs thereby jeopardizing federal certification.
3. Loss of skills by participants can be expected with either "watered down" or reduced programs, resulting in increased dependency and increased behavior problems.
4. There are more (number of persons) for day developmental service than funds to provide those services.
5. The cutbacks have resulted in the necessity of part-time "in-house" programming in ICF/MRs. This could ultimately lead to full-time developmental services in the residential facilities.

D. Alternative Legislative Proposal:'

1. Legislation that defines day developmental services for mentally retarded in both state hospitals and community-based ICF/MRs as a social service to be funded exclusively with CSSA and county funds.
2. Legislation that defines day developmental services for ICF/MR residents as a Medical Assistance Program component and fund those services under Title XIX (as is done in the state hospitals).
3. Legislation that defines day developmental services as a mandatory social service to be funded with state/county funds exclusively either by:
  - a. a client-based voucher system
  - b. grants to vendors (G.I.A.)
  - c. general increase to CSSA
4. Legislation making Department of Education responsible for all preschool day developmental services.

E. Rationale:

- 1.1 This proposal would clarify in statute what is currently happening with regard to county control over community-based day services. It would probably not help attain the goal of this area.
- 2.1 The second proposal, which is recommended, would (according to MR Division analysis) save the counties substantial local dollars, and save the state some dollars.
- 2.2 It would provide equity of rates to counties and state for ICF/MR and state hospital residents (Welsch issue).
- 2.3 It would assure adequacy of quality of programs and remove jeopardy of non-compliance with federal regulations by ICF/MRs in community.
- 2.4 Would not require drafting of new legislation (use modification of Winnia (H.F. 1465) bill introduced last session).
- 3.1 This proposal would help make available more stable funding of developmental services, but would not be consistent with CSSA intent.
- 4.3 

<p>This proposal would reduce county burden and put responsibility with Department of Education.</p> <p>It would have programmatic advantages, according to some experts. by providing transition from preschool programming into special education programming by the same agency.</p> <p>It would open up approximately 1600 spaces in DACs for eligible adults in need of service, but currently under served or unserved (new participants coming from state hospitals).</p>	<p>ity</p>
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Problem Area II

- A. Statement: Minnesota lacks a sufficient number of alternatives to the existing ICF/MR - DAC model of community-based services for mentally retarded.
- B. Goal to be attained:

"To develop a broad array of cost effective alternative to the more expensive ICF/MR - DAC model of community-based services."
- C. Reasons, related issues:
  - 1. Without a stable funding base, or equalization of cost mechanisms, alternatives will not be used by counties even when program-matically superior to the more expensive programs.
  - 2. With current funding formulas, it costs a county more to place a client in a \$10.00 per day SILS program than a \$50.00 per day

3. There are no incentives (subsidies) to use specialized foster care or home-health aide services as alternatives to long-term care placements.

A. With the exception of Family Subsidy for 180 families, there are no incentives (fiscal/programmatic) for families to maintain their retarded children/relatives in their natural homes.

D. Alternative Legislative Proposals:

- \*1. Re-introduce SILS authorizing legislation to define the purpose and Department authorities in the administration of the SILS program.
- \*2. Request legislation to increase number of persons to be served in SILS in an amount equal to projections in Six-Year Plan. (This will call for an increase in appropriations.)
- \*3. Apply for waiver under Title XIX to fund SILS as a "home and community-based service" as an alternative to ICF/MR.
- \*4. Request legislation authorizing specialized foster care for children and adults to be funded under waiver above.
- \*5. Develop comprehensive Home and Health Aide In-Home Program as alternative to ICF/MR or state hospital and foster care.
- \*6. Request increase to Family Subsidy Program to include 300 families and include high-risk adults as eligible recipients.
- \*7. Request additional increases/expansions of sheltered workshop/work activity programs to reduce demand on DAC.
- \*8. Introduce legislation authorizing counties to purchase day developmental services from local school districts.

E. Rationale:

- 1.1 At the present time, we are authorizing and funding SILS programs under the authority of Rule 23. This program should be more firmly founded in statute with SILS appropriations and Rule 23 appropriations combined into a single funding account.
- 2.1 An increase in the SILS appropriation is needed to maintain level of effort due to delayed state appropriation levels for FY 82. Additionally, to meet goals of Six-Year Plan and requirements of Consent Decree, the number of new SILS slots must be increased by 200 for FY 83-85.
- 2.2 We consider this program as very critical to keeping ICF/MR costs down since it currently represents the only alternative to ICF/MR level of care for adult MRs in the community.
- 3.1 This is an ongoing recommendation of the MR Division which has listed numerous rationale for pursuing. Those rationale include consent decree/court order compliance, as well as cost efficiency

(to the state) as an alternative to state and local funds. This legislation is also included in the Winnia Bill (H.F. 1465).

- 4.1 This legislation would be for a new type of service eligible for funding under Title XIX. There may be no need for legislation, however, it may be permissible under the "definition of service" provision of the waiver stipulation. Regardless, this is a "alternative" that should be developed.
- 5.1 This is an old type of service that is very cost efficient and which has been used successfully for home-bound geriatric. The National Council of Home Care, Home Health Aide Services has developed an excellent curriculum for aides working with the mentally retarded. We should move to develop this service in Minnesota as a component of SILS, or, as a cost efficient alternative to either SILS or ICF/MR.
- 6.1 Rationale for FSP increase is grounded in cost efficiency and popular support. The addition of adults can be justified as less expensive alternative to placement in state hospital or ICF/MR.
- 7.1 The recent DPW/DD study of DACs revealed approximately 450 participants would benefit from SWS/WA if available. Expanding this DVR subsidized service would continue to reduce DAC demand and provide necessary spaces for new and existing SILS participants.
- 8.1 Given the economic hard times, it is expected that many school districts would be interested in developing day services if they could generate dollars from the counties. This would provide healthy competition to DACs and could result in reduced costs for such services.

### Problem Area III

- A. Statement: The current 10% cap on (Rule 52) ICF/MR rates is making it extremely difficult for ICF/MR programs to meet demands for program" modifications.
- B. Goal to be attained:  
  
"To modify the Rule 52 rate setting structure to allow rate adjustments beyond the 10% cap for department approved, provider/county-justified program modifications."
- C. Reasons, related issues:
  1. The Legislature imposed a 10%, across-the-board limitation on all MA facilities as a cost containment measure. This measure applies to all facilities (nursing homes and MR facilities) in common manner when in most instances, the MR programs and problems are not common with the nursing homes.

2. DPW's Six-Year Plan is highly dependent upon these facilities discharging their easier to serve residents into semi-independent living situations (SILS) and admitting the more difficult clients from state hospitals. In most instances, this change of population will require a change in program content (e.g., staff, special consultants, etc.) which cannot be made under the 10% limitation. The effect is that most programs are very reluctant to accept the state hospital residents or, when they do, find that they are unable to provide an adequate program for them.
3. County cutbacks in DAC services have resulted in a significant number of residents of ICF/MR remaining at home two extra days per week. In that most ICF/MR staff their facilities on a split shift basis, they are finding it difficult to provide the additional needed hours under the 10% cap.

D. Alternate Legislative Proposals:

1. Propose legislation to lower the 10% cap to 8%, in order to finance limited pass-through provisions in specific, justified conditions such as:
  - a. limit pass through to facilities accepting state hospital residents;
  - b. limit pass through for program changes necessitated by severe behavior disorders and physical disabilities;
  - c. limit pass through to some combination of special need with stringent criteria established and approval by the department.

E. Rationale:

- 1.1 This change is desperately needed if we expect the movement from state hospital to ICF/MR to SILS to continue according to the Department's Six-Year Plan. Without such movement, additional ICF/MRs will be needed costing much more in the long run.
- 1.2 Several programs which have been in operation for over five years with relatively low rates (i.e., less than 35/day) have begun to "turn over" their populations taking much more difficult clients. They have been finding that their staffing patterns are inadequate to program for many of these difficult residents and, under the cap, are either facing the necessity of closing or returning the residents to the state hospitals. For example, 50% of state hospital admissions are re-admissions from ICF/MRs who could not "handle" the behavior problems with their existing staff.

Problem Area IV (General Items) A.

Need Determination:

- \*1. Propose legislation to modify statute requiring commissioner to periodically re-determine need, location and program for mentally retarded persons.

Rationale: Given the broad range of community programs that have developed over the past 10+ years, it is recommended that a periodic (5 years) ratification of the need for those programs be made. By changing the statute, it will be feasible to modify DPW Rule 185. Without such change, the proposed re-determination would probably not be adopted in public hearing.

- \*2. Prepare legislation to change the construction Grant-in-Aid appropriation to be used for either:
  - a. increasing CSSA for day programs;
  - b. remodeling existing facilities (DACs or ICF/MRs) to accommodate class B residents.
- \*3. Brain-Injured Program
  - a. Propose dropping this program.

Rationale: Inefficient use of state dollars.

REQUIREMENTS UNDER WELSCH v. NOOT CONSENT DECREE AND SUBSEQUENT ORDERS OF THE U.S. FEDERAL DISTRICT COURT

1. DAC funding remains the most vexing problem of the entire system of mental retardation services. Some form of legislation needs to be developed and the options range from an increase in CSSA funding for DAC expenditures to exploring an entirely new funding approach such as Title XIX.
2. Semi-Independent Services (SILS) remains, in our judgment, the only viable cost effective alternative to the more expensive ICF/MR program of residential services. The question of how to fund this program to insure its full utilization and success, as well as providing the necessary incentives to counties to use this level of service in place of ICF/MR, remains unanswered. Clearly, we need to develop new legislators on the alternatives if we pursue them, and re-introduce the SILS enabling legislation if the program is to be maintained or expanded. If the decision is to merge with CSSA, then the programmatic and fiscal effects need to be countered somehow.
3. Sheltered work and work activity slots should be expanded to relieve the burden on DACs and to provide appropriate levels of services to those retarded persons who need them. We need to offer supporting testimony to the Division of Vocational Rehabilitation (DVR) (as we did in the last session) in securing additional funds. While this action is not specifically required in the Decree, it is interpreted as a requirement under para. 26 which obligates us to provide "appropriate educational, developmental or work programs, such as public school, developmental achievement programs, work activity, sheltered work, or competitive employment."



Quite obviously, this issue is related closely to the DAC issue since most of the individuals who would use this service now attend DACs. Our past experience with DVR has been very productive and we are continuing to work with them in securing an inter agency agreement on work activity. We need to work for expanded services with DVR.

4. There are a few outstanding areas that deal with appropriation requests for the state hospitals that must be included in our FY 1984-85 budget. One deals with seeking funds to air-condition a part of Fergus Falls State Hospital and another which would secure funds for adaptive wheelchairs for those residents who are physically handicapped. We are working with Residential Facilities Division in getting estimates for these items and will assure that appropriate requests are in the state hospital budget requests. Finally, we must develop a plan for installing carpeting throughout the living areas in the state hospitals housing mentally retarded persons. We are obligated to complete the plan by July 1, 1983, but not the carpeting. Again, we will work with Dennis Boland on this issue.

Summary:

The list of issues is not particularly long, but the items on the list are central to our efforts of compliance and by that fact, are extremely critical.

LEGISLATIVE AND BUDGET PROPOSALS REQUIRED UNDER THE CONSENT DECREE

Because questions continue to surface on the matter of the Commissioner's obligations under the consent decree to "propose to the Governor for submission to the Legislature all measures necessary for implementation of (the Consent) decree" (para. 88), the following attempt at clarifying the issues is offered.

Critical to the interpretation of Part VII, Legislative Proposals (para. 88-90) is the phrase quoted above since it represents a recurring obligation of the Commissioner each Legislative session. Paragraph 89, parts e. through f. specified the legislation to be requested for the 1981 session. The details of that paragraph were drawn, for the most part, from the DPW Six-Year Plan and Biennial Budget Request document, and as a result, posed no serious problems in determining our relative compliance.

Paragraph 88, which is applicable to this session and all subsequent sessions, has a much broader and encompassing nature in the phrase, "...all measures necessary for the implementation of this decree". In other words, it is first necessary to consider all the stipulations in the decree and to then determine if and what legislation is necessary to meet those stipulations. In order to perform such an analysis, one must examine the entire Mental Retardation System of Services with special attention to the interrelationships and inter dependencies of the many component parts of that system.

That task is completed in this status report, which proposes solution options. Once a general approach is selected (e.g., Title XIX), a detailed proposal can then be developed with all attendant recipient numbers and dollar costs/savings.

At some risk of oversimplification, the Commissioner's obligation can be summarized thusly:

1. We need to continue reducing the population in the state hospitals to no more than 2,100 by July 1, 1985, (para. 14), (a net reduction of approximately 250 from current levels);
2. We must assure that appropriate community alternatives are developed (or secured) for them (para. 16, 24, 25); and
3. We must assure that those persons who are discharged also receive appropriate day programs (para. 26).

The question to which we must now turn is how can we meet the three-point obligation above without exceeding the 10% dollar cap on the Medical Assistance Program (for residential services) and without statutory authority to mandate county funding of day program under CSSA. Perhaps a better way to phrase the question is "can" rather than "how" do we accomplish this. Our analysis of the situation and the options available to us lead us to conclude that without a substantial increase in state appropriations, we will not be able to meet our goals within the 10% MA cap.

We are currently in a "Catch 22" situation of the first class. If we attempt to live within the 10% MA dollar cap, we will immediately need to stop all new ICF/MR development since those which have already been approved to open will eat up that increase. Even if we reduce the rate increase limit to 8%, that will only result in a savings of approximately \$1.4 million, a figure hardly sufficient to accommodate the nearly 300 beds scheduled to open over the next eighteen months. Of those 300 beds, less than one third are "reserved" for state hospital discharges, far short of the number needed to meet the Welsch quota.

A strategy that we have proposed is to expand significantly the SILS program to move persons out of existing ICF/MRs which would create vacancies for state hospital residents. This, we believe, is a sound and cost effective strategy; HOWEVER, unless the disincentives to both counties and ICF/MR providers to use this program are removed, the most we can expect is that most of the SILS slots will be filled with existing community clients and, those vacancies which do occur in the ICF/MRs will very likely be filled with persons from the same source - the community. The reasons for this have been repeatedly discussed in our tri-divisional meetings. Residential providers will not accept the more difficult-to-handle state hospital residents without some provision in the rate setting process that will permit the necessary program modifications (typically increased staffing levels).

Their insistence on such a provision is legitimate since in most instances, the Title XIX regulations mandate higher staff-to-resident ratios for the more severely disabled client. The current 10% rate cap does not permit

such program modification or staffing increases. Therefore, a request for an increased SILS appropriation without such a provision in the rate setting process will not accomplish our objective and subsequently, fails to meet the "all necessary measures" criterion of the decree with regard to residential placements.

Since our goal is to hold down state expenditures while simultaneously removing the disincentives to using the SILS program we must utilize the MA waiver option for this program.

That decision is a major policy direction for which this Department failed to secure legislative support in the last session. The critical issue here is whether we try again, or focus on the other options which I believe will cost the state and counties considerably more money.

The MA Waiver decision, more than anything else, will dictate the types of legislation we will develop for this session since upon it hinges the direction we will pursue in the funding of community-based programs and services for the mentally retarded.

The matter of adequate funding for day programs, DACs in particular, is equally complex. We see two options available to us: utilization of Title XIX for all ICF/MR residents, or, a massive increase in CSSA with no capability to assure that the funds will be used by the counties for DAC services. Again, we are back to the pivotal decision on the MA program and the Waiver option.

Therefore, before we can "package" our legislative proposals in a fashion that will assure compliance with the Consent Decree, we must have a decision on whether we attempt to use MA or, we seek state funds. In either event, our problem with exceeding the 10% cap due to ongoing ICF/MR development must be resolved quickly.

The purpose of this status report is to clarify the very difficult position in which we find ourselves. Please advise us on which way to proceed so we can begin developing the specifics of our legislation and budgets.

STATE OF MINNESOTA

# Office Memorandum

DEPARTMENT      **Public  
Welfare**

TO :              **Advisory Council**

DATE:          **9/20/82**

FROM :          **Ardo Wrobel** 

PHONE:

SUBJECT:        Status of department legislative proposals as of September 7, 1982,  
concerning MR programs.

Foster Care Bill -- This bill would amend Minnesota Statutes 257.071 (Children in Foster Homes; Placement; Review) to require foster parent and foster child involvement in developing case plans for children in foster care; and would identify in statute those actions that residential facilities should take to encourage the return of the foster child to his own home.

CSSA Bill -- This bill would amend Minnesota Statutes 256E.09 to strengthen in home services and permanency planning services in CSSA plans; and would administratively integrate the current categorical programs of

1. Day Care Sliding Fee
2. Rule 14 - Chronic Mentally Ill
3. Rule 23 - Sils related (not SILS)
4. Children Under State Guardianship

into the CSSA Block Grant.

D. SILS Bill -- This bill would:

1. Establish SILS as a statewide program and establish its overall purpose.
2. **Authorize the Commissioner to award grants for SILS.**
3. **Specify maximum and minimum funding limits.**
4. **Provide the Commissioner with rule-making authority concerning SILS grants.**

H. Licensing Fees & Exemption from Business Licensing Act Bill - This bill would:

1. Amend Minnesota Statutes Chapter 245 to increase the ceiling on licensing fees to \$1,000 and remove the exemption of residential facilities for the mentally retarded for paying a fee.
2. Amend Minnesota Statutes 245.782, Subd. 6, to define "facility" to mean a physical structure and "program" to mean a cohesive set of services.
3. Amend Minnesota Statutes to provide for the licensure of adult foster homes.
4. Amend Minnesota Statutes 362.452, Subd. 2A, to exclude the Department of Public Welfare from the Business Licensing Act.

## II. BILLS REVIEWED WITH DECISION HELD

B. 0 - 3 Education for MR's Bill - This bill would make the Department of Education responsible for all preschool day developmental services for the mentally retarded.

COMMENT: Prepare draft - okay if Education is not opposed - involve Education.

C. Community Mental Health Boards Bill - This bill would amend Minnesota Statutes 245.61 - 245.60 to maintain specific statutory authority for certain mental health entities; establish certain mental health definitions; and to provide statutory authority for the physician-directed clinic enrollment category in MA.

COMMENT: Need more information - prepare draft.

G. Rule 52 Rate Increase Cap Bill - This bill would reduce the 10% cap on Rule 52 rate increases to 8% with justifiable exceptions for facilities accepting state hospital residents and persons with behavior disorders in order to maintain community placement options for difficult clients as specified in the Department's Six Year Plan for Mentally Retarded.

COMMENT: Hold until decision is made on MA budget - then if needed, fold into the MA program bill.

I. HA Program Bill – This bill would amend Minnesota Statutes 256B to:

1. Lower the 10% cap on providers to 8\*. (See also Rule 52 proposed bill).
2. Require that DPW be notified of any potential tort actions brought by current or former MA recipients for whom DPW may have paid medicals.
3. Establish a single resource standard.
4. Eliminate the RSDI COLA disregard;
5. Clarify the language in 256B.06 so that it more accurately reflects current eligibility policy; and
6. Authorize DPW to convert outpatient hospital billing to the same standard as physician clinics.

COMMENT; Hold for decisions on Income Maintenance Budget.

Long Term Care Bill – This bill would establish an "independent living program" addressing the long term care need of Minnesotans, The DPW would be designated the State entity for inter agency coordination of Long Term Care Planning and Policy Development. Funding would be provided as a categorical program for the first 3 to 4 years and eventually would be folded into CSSA.

F. Regional State Hospitals Bill – This bill would change the current method of funding and operating the state hospital system by:

1. Establishing regional governing boards for each state hospital comprised of county representatives and members at large.
2. Granting the governing boards discretionary power to use part of the hospitals' budgets for mental health treatment programs throughout their catchments areas.
3. Allocating the state funds for each state hospital catchments . area on the basis of a per capita formula thereby assuring an equitable distribution of such funds to all regions of the state.

COMMENT: No decision. More detail needed.

|. Title XIX Funding of DAC's Bill – This bill would provide coverage of DAC's by Title XIX (MA).

COMMENT: Hold pending decisions or. Income Maintenance Budget, and completion of DPU study for the Legislature.

Unless you indicate otherwise, the Department will begin preparing draft bills for all topics which were tentatively approved and will submit these draft bills to the Reviser's Office as soon as possible. Submitting bills to the Reviser's Office at this time will avoid the crunch that will come later when all the DPW bills which have been held pending budget decisions and all the bills other agencies are preparing are submitted.

We will also review our list of bills to see if we can reduce the number of bills. We will keep you apprised of all funding sensitive issues which arise concerning any piece of the Department's 1983 Legislative Package and as soon as the critical decisions on our Department budget are made we will re-submit those bills which have been held for your re-review and approval.

# COMPREHENSIVE

FOR THE MENTALLY  
RETARDED AND  
DEVELOPMENTALLY DISABLED  
IN MINNESOTA

MARCH, 1975

MR/DD PROGRAM OFFICE  
COMPREHENSIVE PROGRAM BUREAU  
DEPARTMENT OF PUBLIC WELFARE  
ST. PAUL, MINNESOTA



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Authority, of the Commissioner of Public Welfare

The commissioner of public welfare is constituted as the "state agency" as defined by the Social Security Act of the United States (M.S. 245.04) and the laws of this state (M.S. 246.01) for all purposes related to mental health and mental hygiene. This includes promoting the enforcement of laws protecting defective children and supervision of all non-institutional services to handicapped persons (M.S. 256.01). Minnesota laws further provide that the commissioner of public welfare shall actively cooperate with other departments, agencies and institutions, local, state and federal, relating to the care and supervision of individuals, both prior, to, and after departure from institutions, under the supervision of said director of institutions.

M.S. 245.70 designates the commissioner of public welfare as the state agency to administer a state-wide plan for the construction, equipment, maintenance, and operation of any facilities for the care, treatment, diagnosis, or rehabilitation of the mentally retarded, which are or may be required as a condition for eligibility for benefits under any federal law and, in particular, under the Federal Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (P.L, 88-164). The commissioner of public welfare is authorized and directed to receive, administer, and expend any funds that may be available under any federal law or from any other source, public or private, for such purposes, and enter into agreements with other departments of the state, as necessary, to meet all requirements of the federal government (M.S. 256.01).

M.S. 245.072, MENTAL RETARDATION DIVISION, provides that a mental retardation division is created in the department of public welfare which shall

coordinate those laws administered and enforced by the commissioner of public welfare relating to mental retardation and mental deficiency which the commissioner may assign to the division.

## FOREWARD

This plan

1. Gives direction to the Department of Public Welfare goal of developing a community-based program for persons who are mentally retarded or otherwise developmentally disabled.
2. Begins to investigate alternative strategies in achieving the above goal.
3. Establishes an evolutionary strategy in how the Department of Public. Welfare's goal will be achieved.
4. Provides for participation of persons from each of the four functions that make up the service delivery system (Chapter III, A & E).

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The state of the art in planning for a target group of handicapped people in the general population dictates that this plan address the process of (1) assessing the needs of the target population and determining priorities in meeting those needs, and (2) defining the service delivery system and adapting it to meet the needs of the target population.

Considerable effort in the Department of Public Welfare has gone into establishing the framework for a community-focused service delivery system and funding it through local, state and federal sources. Whether Minnesota's program will become principally community-based through increased development of community alternatives to institutionalization is yet to be de-

terminated by the community and legislature. The development of community alternatives is the subject of the Department of Public Welfare. Comprehensive Plan and legislative budget requests.

The main thrust of services for persons who are mentally retarded or developmentally disabled is to provide assistance to enable them to live in 'their own homes. When this is no longer possible or desirable, efforts are directed toward placement in a community-based residential facility, providing it can carry out a plan of services to meet the person's developing needs. Placement is made in one of the state institutions when suitable community programs are not available.

While the population in the state institutions has been significantly reduced over the past 10 years, the higher level functioning persons with less complicated physical and developmental problems have been placed in community-based facilities, including some inappropriate placements in nursing homes. Development of community-based programs must address all of the needs of a developmental program and identify specific groups for such programs from both the state institutions and nursing homes.

The extent to which community-based programs are more desirable than state institutions for the more complicated physical and developmental problems has been studied. These studies indicate that approximately one-half of the existing population in state institutions could be better served in appropriate community-based programs. Department of Public Welfare, planning and legislative proposals for the 1975 session are directed toward the establishment of community alterna-

tives and the development of a service delivery system within each local area (area board).

Specific legislative requests include: (1) family subsidy over and above room and board for needed services in order to maintain children in their own homes; (2) equalization of cost to counties for care in community-based facilities and state institutions to reduce costs as a factor in making appropriate placements; and (3) loans for the construction and remodeling costs of community-based facilities.

Study of certain other documents related to this phase of the plan may be helpful in understanding the techniques being used in developing the service delivery system

Community Alternatives and Institutional Reform (CAIR) Report, a Developmental Disabilities Project.

A Report to the 1973 Minnesota State Legislature on the Status of Minnesota's Mentally Retarded Citizens Residing in State Hospitals, by Minnesota Department-of Public Welfare,

Section VI, Department of Public Welfare grant in aid application form for area MH-MR boards.

Department of Public Welfare Policy Bulletin #5, concerning the area MH-MR board responsibilities in planning.

Memorandum to area MH-MR boards from Vera Likins, Commissioner, concerning Area Planning for Community Alternatives, dated January 13, 1975.

Outreach Training Program for Personnel Serving the Mentally Retarded in Minnesota.

(draft) Minnesota Department of Public Welfare Advocacy Procedures.

(proposed) Amendment to M.S. 252.27, concerning family subsidy.

(proposed) Minnesota Protection Act, concerning guardianship and conservatorship.

## CHAPTER I

### Introduction

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This document is that section of the Minnesota Department of Public Welfare's Comprehensive State Plan that deals specifically with planning for mentally retarded and developmentally disabled persons in Minnesota. An effort has been made to develop a plan that is consistent with the contemporary philosophy of service for handicapped persons. This philosophy includes the principle of normalization, the developmental model, and individualization of all services to the mentally retarded and developmentally disabled.

Further, the recommendations in this plan will address themselves to these five goals adopted by the Department of Public Welfare:

1. The Department should perform a broad-based standard-setting, coordination, funding, monitoring and evaluating function.  
providing direct services by delegating the management and operational responsibilities for these services to the local level.
3. The Department should carry out its role in program and service delivery indirectly through long-range program and budget planning, development of licensing and funding standards, funding local community-based programs and services via grant-in-aid and reimbursement mechanisms.
- A. All residential and non-residential service delivery systems for which the Department is responsible should be fiscally and administratively integrated into a single, community-based program, under local control. The reorganization and functioning

of the Central Office should be modeled upon and geared toward providing support for this local delivery system.

5. In order to carry out the functions listed above, the Department must give top priority to the continuing development and Implementation of an adequate management information system which will provide needed information in areas of cost finding, rate setting, target population needs assessment, and feedback on the appropriate accountability of public funds can be guaranteed.



## CHAPTER II

Division of Mental Retardation and Developmental Disabilities (MR/DD Program Office).

The MR/DD Program Office was established in M.S. 245.072 and is the responsible office for planning and coordination of services to the MR/DD population in Minnesota. The role and responsibility of this office is to develop procedures and techniques that enable it to:

1. Continually assess the needs of the MR/DD population currently being served throughout the system,
2. Identify that MR/DD population in need of services who are not being serviced in the system,
3. Determine developmental services needed by area and category,
4. Define and evaluate the current delivery system and provide guidance in determining needs for increasing or decreasing certain components of the system,
5. Describe fiscal, legal, and policy support of the delivery system and determine changes needed including ways to improve the coordination among and between the four functions,
6. Manage a process model for the articulation of goals and objectives from the local level through central coordinating for the purposes of prioritizing and communicating state-wide goals and objectives identified within and for the system,
7. Examine and study existing accreditation, licensing and other standards and assist in implementation and evaluation of such monitoring functions.

This office, concurrent with the filing of this report, will be initiating a

## CHAPTER III

### The Service Delivery System

#### A. The Four Functions

The major theme of this plan is the description of a process model for the planning, coordination, and subsequent delivery of appropriate services to the mentally retarded and developmentally disabled. The complexity of the system dictates the use of a new and unique approach for describing its functions. Four functional categories aid in conceptualizing the organization of the wide array of services available to the target population. These functions are:

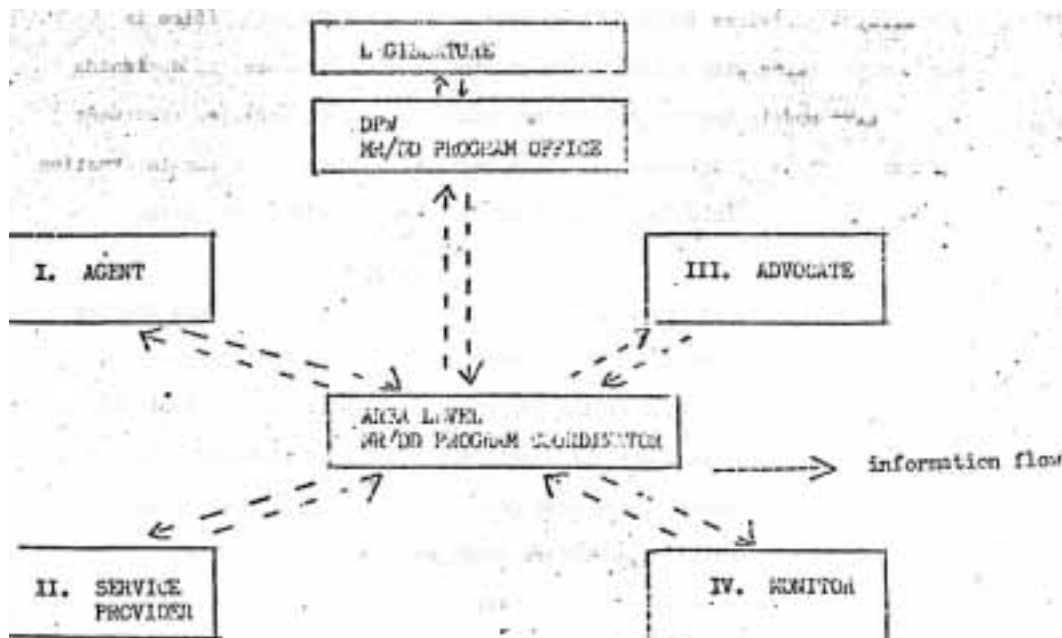
1. To act as agent for the individual. Persons who function as agents for the individual include the parent and county welfare department. This function summarily consists of assessing the needs of the individual, developing a plan for services, arranging for those services, and monitoring his progress. The agent also arranges for payment of those services.
2. To provide the service he needs. The service provision function includes all residential and day developmental programs which provide services to individuals needing assistance. These services include community-based residential facilities, state institutions, daytime activity centers, sheltered workshops, work activity centers, public schools, as well as health, medical, mental health, and recreation services available to the general public.
3. To advocate for the individual. Persons fulfilling this role include parents, relatives and interested persons. Organizations who advocate for the individual include the Minnesota Association for Retarded Citizens, United Cerebral Palsy, Minnesota Epilepsy League, Advocacy

Society, the courts, Family and Guardianship Services and Consumer Concerns.

A. To monitor those services provided. The monitor function includes governmental agencies who are responsible for licensing, certification, management, and supervision.

B. Area MR/DD Functions

Traditionally, the "total institution" approach to service delivery has caused the agent, advocacy, and monitoring functions to be subordinate to the service provider function. This plan seeks to develop a community-based service delivery system (Figure 1) for the delivery of services that will provide a balance among and between the four functions at the community level. The mechanism for achieving this balance must be the community agency with responsibility for coordination and planning, and whose structure affords representation to each of the four functions. This plan identifies the Area MR/DD Program Coordinator and the Area Board as this community agency.



Minnesota Statutes 252.28 gives the commissioner authority to determine need, location, and program for residential and day programs. Area Mental Health and Mental Retardation (MH/MR) Boards have been delegated authority to assist the commissioner in making these determinations.

Consequently, the MH/MR Area Board plays a key role in determining the quantity and quality of services available to MR/DD persons. This role of the MH/MR Area Board mandates the development of an area service plan which addresses each of the four functional service areas. The Area MH/MR Board is the "forum" at which representatives of agencies performing each of the four functions share and solicit information about the service system. It is expected that each MH/MR Area Board will make use of their MR advisory committees required by M.S. 245.61, to conduct this activity.

An information system is a prerequisite for the planning and coordination of the array of services found in each area. The MR/DD Program Office is currently working with a task force of area program personnel in designing alternative models for the collection, standardization, storage, treatment and presentation of information. This model will insure that the information collected is accessible in all areas of the state to aid in planning.

#### C. Implementation of Previous Deinstitutionalization Efforts and Studies

1. Community Alternative in Institutional Reform (CAIR) Report The Comprehensive Plan of the Department of Public Welfare (released in December, 1974) includes the development of community-based alternatives to state institutions. Federal government goals charge the Department of Health, Education and Welfare (HEW) to bring its resources to bear on attaining the goal of reducing state institution population by 50% over

The Department of HEW made available certain national significance project money through Developmental Disabilities Councils to plan for an orderly development of community alternatives and institutional reform. This project was directed through the Developmental Disabilities Council staff, and a state level CAIR committee. This project, initiated in July, 1973, concludes with publication of the CAIR report in January, 1975. This report is available from the Division of MR/DD Programs, or the Office of the Developmental Disabilities Council.

This report will be used as a guide to augment Department goals and policies by various components of the service delivery system at the local and state levels of responsibility. A plan for implementing the CAIR report will be developed in cooperation with staff of the Developmental Disabilities Council soon after publication of the report.

Implementation plans and cost studies will be made. The cost study is planned for presentation to the 1975 Legislature in March, 1975. This study is also being conducted by the Developmental Disabilities Council.

The CAIR plan will be used by Area MH/MR Boards, county welfare departments, state institutions and community-based service providers and advocates. Each is expected to carry out its appropriate (function) responsibilities as provided in law and policy.

## 2. Community Resistance Study

The Department of Public Welfare employed Earl Craig Associates, Inc., to propose a strategy for combating community resistance to the development of community-based residential facilities and programs for mentally retarded and developmentally disabled children and adults. This report has not had

amendments to state laws concerning local zoning authority will be made by DPW and/or state advocacy groups. The preliminary report to DPW cites suggestions in the campaign to develop facilities. Lack of clear statement of DPW commitment to the concept, red tape, lack of coordination lack of money, public ignorance and fear about retarded persons, as well as hostility and fear of neighborhood residents, contribute to this problem. Subsequent political decisions to deny special or conditional use permits to facility developers also slow the growth process.

The preliminary report lays out a political strategy, and recommends

1. Clear statement of state policy,
2. Comprehensive plan for development of community-based facilities,
3. Staff to encourage more community programs,
4. Staff to assist developers,
5. DPW generate support through trained community organizers  
on the local level,
6. Use argument that retarded/developmentally disabled are no  
more likely to behave in socially pathological ways than any  
group not in group homes,
7. DPW seek legislation to remove or lessen local discretion  
regarding location of group home for the retarded, and
8. Public education about the normalization principle, state  
commitment, policy and plans, and group homes.

#### D. Developmental Disabilities (DD) Council

The DD Council is a state level forum for cooperative planning with other agencies, groups and activities related to the agent, provider, advocate and

Public Law 91-517 created a National Developmental Disabilities Advisory Council to the Department of Health, Education and Welfare. HEW makes grants to states to establish and staff state councils. The councils are appropriated money for the purpose of state level planning, conducting state significance projects and providing direct services that state agencies lack resources In The Minnesota DD Advisory Council functions in the State Planning Agency. Regional counterparts are attached to the Comprehensive Health (B agency) regions for Planning and coordination.

Responsibilities and functions will be studied early in 1975. E. Time Lines for Implementation of the Plan Timetable and strategies in developing the state plan by September 1, 1976, are as follows:

Step I. February 1, 1975 to March 31, 1975

- A. Submit document to representatives of the four functions and the Area MH/MR Boards in order to correct and update this description of the current status of the four functions. Representatives of each function are listed below.

Agent - county welfare departments, field services staff, function income maintenance division, coordinator of individualized program planning.

Provider - state institutions, Residential Services Bureau, function Association of Residences for Retarded in Minnesota, Minnesota Department of Health, Divisions of Vocational Rehabilitation and Special Education of the Department of Education, and Developmental

Advocate - Minnesota Association for Retarded Citizens, United  
function Cerebral Palsy, Minnesota Epilepsy League, Consumer .  
Concerns Division, Advocacy Committee of the  
Developmental Disabilities Council, Legal Aid.

Monitor - Licensing Divisions of DPW and MDH, Rule 52 rate  
function setting staff, Technical Assistance Project Staff,  
Technical Consultation staff of MDH," Outreach Training Program staff, DAC  
Advisory Committee, Licensing Committee of the DD Council, and  
the Mental Retardation Licensing Advisory Board. April 1, 1975 to  
April 30, 1975 Update document so that it accurately defines the  
current service delivery system in its four basic functions, and  
so that it can be used as a reference manual to the MR/DD service  
delivery system.

Step II. May 1, 1975 to June 30, 1975

Submit the updated document (Step I) to state-wide representatives of  
the four functions, and to all Area MH/MR Boards, for recommendations  
concerning the operation of the four functions.

Step III. July 1, 1975 to August 31, 1975

- A. Study recommendations resultant from Step II to determine DPW  
priorities, changes and activities.
- B. Study all Area IIR/DD Board plans to determine DPW priorities and  
activities for program budget planning and legislative (July 1, 1976  
through August 31, 1976) presentation.

Step IV. September 1, 1975 to December 31, 1975

Prepare DPW Comprehensive Plan for Mentally Retarded and Developmentally  
Disabled in Minnesota for

- 1. Public hearing
- 2. Changes that can be accomplished within authority and



3. Changes that can be accomplished by agencies and organizations through negotiation and cooperative planning
4. Reorganization
5. Reviewing legislative proposals through program budget responsibilities
6. Use within the agent, provider, advocate and monitor functions
7. General public

Step V. January 1, 1977 to January 1, 1979

Repeat Steps 1 through IV to keep the Comprehensive Plan current and updated on a biennial basis.

## CHAPTER IV

### Status of the System by Function

#### A. The Agent Function

Generally, three categories of persons or agencies are identified who function agents for the developmentally disabled person: parents or relatives, county welfare department social workers and, in the case of committed wards, the Family and Guardianship Section of the Residential Services Bureau. While the function of these individuals may vary slightly, the principle of individualized program and service planning is of paramount importance

Following is a description of agent responsibility;

##### 1. Diagnosis of Mental Retardation

The county welfare department is responsible for the coordination of effort in diagnosing a person as mentally retarded. Legal definitions of mental retardation are available in the DPW Social Services Manual.

Parental history alone is insufficient for diagnosis of mental retardation. DPW requires the following information for the diagnosis of mental retardation:

1. Family history
2. Medical prenatal and birth history
3. Early developmental history
4. Comprehensive psychological evaluations
5. School reports indicating behaviors, as well as functional levels
6. Psychiatric evaluations if indicated by the other reports
7. Vocational evaluation reports
8. Observations and interviews about family and the environment

be made yearly, with new evaluations secured as needed.

Comments/Recommendations:

## 2. Assessment and Subsequent Planning to Meet the Client's Needs

The CWD is also responsible for assisting any person who is mentally retarded or developmentally disabled by assessing that person's needs and subsequently planning to meet these needs. These individuals' needs can be met through a variety of services available in the community.

If placement in a residential facility is necessary, planning becomes a cooperative effort of the client, his family, representatives of the residential resources (state institution or community based facility), and community day services as needed.

The CWD is financially responsible for these services, providing the Department deems the individual or parents of a child under 13 years of age unable to pay. The placement facility is then responsible for the delivery of services as determined by the individual's plan. The facility staff is required by regulations to develop this plan of services.

Comments/Recommendations:

#### Individual Program Planning

The common theme underlying all service to the MR/DD in Minnesota is that program and services must be specifically tailored to each individual based upon his needs. The Department of Public Welfare in 1974-75,, cooperatively with the University of Minnesota, has developed a standardized behavioral assessment and program planning system entitled the Minnesota Developmental Programming System, In addition to developing the necessary instrumentation, computer-based scoring capabilities, and related materials and forms, this project also has trained a state wide sample of representatives of all service agencies. This particular system is not mandated, but rather endorsed by the MR Program Office as meeting ICF regulations, Rule 34, and program office standards of Individualized Program Planning.

Comments/Recommendations:

#### 4. Family and Guardianship Services

The Family and Guardianship Section, Residential Services Bureau, is delegated guardianship responsibilities, as provided in M.S. 246.01. Guardianship, through court order, is vested in the Commissioner of Public Welfare and includes guardianship of estate and person, mental testing, and consent to marriage.

County, welfare departments (M.S. 393.01 - 393.07) are responsible for the supervision of wards of the commissioner (M.S. 203.07, Subd. 2), and when designated, to act as agents of the commissioner in the placement of his wards.

Such placement designation is carried out by the Director of Family and Guardianship Services, and the CWD concerned. This includes consultation and assistance to the counties in planning. Cooperation with the courts in determining appropriateness of guardianship and reviews of the continued need for guardianship of individuals are required. Petitions to the courts for restoration are made when such guardianship is no longer in the best interests of the ward.

Guardianship is ordered by the court when the person is in need of protection, which gives ordinary and extraordinary parental authority over the ward. This status reduces the person's rights to that of a minor child, and assigns such authority to the commissioner.

Comments/Recommendations:

5. Income of the Client

a) Income Maintenance

Dependent on income, MR/DD persons for reasons of permanent disability (as. defined by Social Security amendments), are eligible for Income Maintenance payments if they are not living in an ICF/MR facility. Such payments are for room and board expenses, ordinarily considered to be living independently in his own home. Supplemental payments can be added to this by the CWD through state supplemental assistance appropriation?. Department rules govern this combination of income maintenance.

Note: Mentally retarded and developmentally disabled persons needing care and services above the level of room and board, as certified by a physician (proposed DPW Form 1503-A), but below the level of a skilled nursing facility, are eligible for placement in an ICF/MR facility and, therefore, Income Maintenance does not apply.

Comments/Recommendations:

b) Supplemental Security Income (SSI)

Residents of ICF/MR facilities (~~ex~~cept children being paid out of state appropriated cost-of-care program (M.S. 252.27), are eligible to receive \$25.00 per month personal needs allowance paid through Social Security. This is administered through the Minnesota Social Security Office, and application must be made by the individual, the county welfare department, or facility staff may act for him). This meets needs over and above those provided by the residential facility.

This personal allowance cannot be used to pay for items of service that the facility is expected to provide.

Comments/Recommendations:

c) Special Personal Needs Allowance

If the resident of an ICF/MR. facility is employed in a sheltered workshop, work activity center or is competitively employed part-time, DPW Policy Bulletin #40, dated 4/25/74, provides for a special personal needs allowance before he must contribute toward his care and services. This allowance provides for deduction of work expenses, and up to \$50.00 of earned income. The remaining salary goes toward his care.

The above formula is approved by HEW for purposes of determining income that is countable in determining eligibility for SSI payment

M.S. 252.24, Subd. 4, authorizes the board of directors of a daytime activity center-(DAC) to charge a reasonable attendance fee, based on the ability of the mentally retarded person, his guardian or family to pay such fee, provided that no person shall be denied participation in the activities of the DAC because of inability to pay such a fee. Fee schedules must be approved by the Commissioner of Department of Public Welfare.

Parents and relatives may voluntarily pay more than is provided in Minnesota Statutes.

Comments/Recommendations:

## 6. Payment for Services

### a) Parents

CWDs are required to assist parents and MR/DD persons in planning and provision of services. The parents' ability and level of payment is determined by an income/expenses formula.

Eligibility for services in residential facilities under Title XIX,



Cost of Boarding Care under provision of M.S. 252.27 (Cost of Care Program).

M.S. 252.27 provides that parents must pay up to 10% for costs of such care and services, if the DPW income/expenses formula shows this ability. This also applies to parents of a child in a state institution.

Parental obligation to pay is limited to children under 18 years of age. The 1973 Legislature amended the statutes to provide that parental obligations not exceed \$60.00 per month, for care in community-based facilities or state institutions.

b) Residents

**If the resident of a community-based facility or a state institution** has income, estate or inheritance, in excess of the various eligibility limitations for federal or state paid care and services, Minnesota laws obligate the resident to pay up to the total amount of his care costs, until such time as he becomes eligible for such care at public expense.

Residents who are employed as a part of the individualized program plan in a sheltered workshop, work activity center, or are competitively employed, are obligated to contribute to their cost of care and services. The amount they pay is based on the excess as allowed for deduction in the Special Personal Needs Allowance (see Chapter II, A, 5). The Special Personal Needs Allowance provides for payment after deduction of work expenses and up to , \$50.00 per month earned income.

Comments/Recommendations:

B. The Provider Function

Minnesota offers a wide array of services available to the MR/DD population. A study conducted in February, 1973, of that population served by the state hospital system since 1900 shows a drastic trend reversal in the numbers of persons served by that system. Minnesota has adopted and is working toward the goal of providing as many services as possible in the community. This section will describe the kinds and numbers of services available, as well as where and how they are being provided.

1. Community-Based Developmental Services

The community approach expects that a person lives in a homelike facility, or in his own home, from which he leaves for work, education and recreational activities. Activities are available to the MR/DD in the community that somewhat duplicate, or substitute work/education/recreational activities, in order to approximate normal patterns of community living and life style.

DPW Rule 34 requires such activities to be available to residents. Those physically unable to access the community must be provided with these services of equal quality in the facility. Size, location, tradition and condition of its residents, allows the state institution to continue providing many developmental services

within the institution. Notable exceptions are the provision of vocational and educational services, the Cooperative Vocational Rehabilitation Program (CVRP), the mandatory provision of the Special Education Act, and the Foster Grandparent Program. DAC-type services and training, health and medical services, are provided by institution

a) Daytime Activity Centers (DAC)

Minnesota Statutes 252.21 through 252.26, authorizes grants-in-aid to assist local units of government or nonprofit corporate organizations in the provision of DAC services to mentally retarded and cerebral palsied persons who can benefit from such services. DAC's are subject to licensing and supervision by Department of Public Welfare, as provided in U.S. 252.23 and 252.24. Specific licensing standards are in the process of development through the DAC Advisory Committee and the MR Licensing Advisory Board. These new standards will replace the use of DPW Rule 3. The DAC law further authorizes local city, town, village or county taxing authority for DAC's provide for a board of directors, eligibility criteria and attendance fees based on ability to pay.

Since passage and implementation of the mandatory TMR Act of 1971, the number of children of school age in the DAC has been significantly reduced; however, some persona continue to be served through contracts with the responsible school districts. This act has resulted in a major shift in function, more nearly carrying out the intent and provision of the DAC law, by serving pre-school children and adults.

Concurrently, the MR facilities licensing law and DPW Rule 34, require

facilities who are otherwise eligible and can benefit according to assessed needs. This has resulted in the identity of DAC's as a major developmental resource and activity in their own right.

Local county and state expenditures for DAC's are reimbursed through federal Title IV-A Social Service funds 'at 75% for eligible recipients.

a) The Minnesota Daytime Activity Centers Association (operators) is currently developing a DAC Evaluation System, under a Developmental Disability Project grant. The purpose is to develop an instrument that can produce information used to evaluate the program from service and fiscal points of view. The system will also be used by local CWD, Area MH/MR Boards, DPW and DAC operators and boards for their purposes. DPW is responsible for supervision and the provision of program consultation. Arrangements are being made for the provision of consultation through the area MR coordinators.

Eligibility criteria is not clearly established for DAC services. The law provides for services to M1 and CP persons who can benefit from the level of services provided. However, assessment of need, and diagnosis of mental retardation or cerebral palsy is not currently required for eligibility purposes. This situation is not consistent with Department policy that all placements in residential facilities, including state institutions, be arranged through the appropriate CWD.

Comments/Recommendations:

b) Special Education

Public school special education services are mandatory for mentally retarded and other developmentally disabled children of school age

Minnesota Statutes 120.17 HANDICAPPED CHILDREN, provides for special instruction by or through the local public school districts.

Mandatory special education services for educable children became effective in 1965, followed by mandatory programs of instruction for trainable mentally retarded children, effective July 1, 1972.

The Special Education Section of the Department of Education, in cooperation with the Division of Mental Retardation and Developmental Disabilities, established guidelines for the mandatory TMR provisions of the Special Education Act. These guidelines define "trainable" as a retarded child of school age who is not educable, but can benefit socially, physically and/or psychologically from special instruction. In effect, any retarded child who is not educable is considered trainable, unless they are demitted from school attendance under provision of M.S. 127.071, and guidelines of the Department of Education.

Children living in their own homes, someone else's home, or in any community-based residential facility or state institutor, must be provided with public school educational services by the school 'district in which he/she is currently living. The child's home school must pay the costs of such services if provided by another school district. Schools may purchase or contract for appropriate services (i.e., a DAC), until more appropriate arrangements are made by the school board. Schools are expected to cooperate for the provision of a full sequence of services when districts have less than the minimum number of eligible children.

Implementation of the mandatory provisions of the Special Education Act has resulted in approximately 50% eligible children receiving services while residing in the state institutions during the 1972-73 school year; 70% during the 1973-74 school year; and nearly 100% during the current 1974-75 school year. (There are approximately 1,400 school age children in state institutions.)

Because school districts must now pay for the education of children whose legal residence is in the district, but who reside in state institutions, the school boards are now seriously considering a number of options, among which is to provide such services in the child's home school district. This has renewed interest in getting the child returned from the state institution and placed in his own home or in a community-based residential facility. This process requires cooperative planning between state institution staff, the CWB, parents and the school board.

strengthen community interest in serving mentally retarded as close to home as possible.

Comments/Recommendations:

C) Vocational Rehabilitation Services A variety of vocational rehabilitation services is available to MR/DD persons.

Vocational diagnostic services are available from vocational rehabilitation counselors. Such services include arrangements over a period of time in various sheltered workshops in the state. Such services are also available to residents of state institutions through the Cooperative Vocational Rehabilitation Program (CVRP), operating for six years. Following diagnostic services, a variety of arrangements may be made to assist the person in attaining his work potential:

1. Assistance in securing part-time or full-time competitive employment,
  2. Employment in a sheltered workshop,
  3. Therapeutic work activities in a work activity center
- (M.S. 2A6.56).

Minnesota Statutes 121.714, Subd. 4, provides for certification of all long-term sheltered employment and work activity programs by the Commissioner of Education. Such certification is required for funding through the Division of Vocational Rehabilitation, Department of Education. Funding is based on the Minnesota State Plan for Rehabilitation Facilities.

United States Department of Labor regulations apply to these services. This includes the payment of minimum wages, if sub minimum wage certificates are not issued by the Minnesota State Department of Labor and Industry, based on the individual's productive limitations imposed by his disability. These limitations determine whether the person is engaged in:

- Long Term Sheltered Employment Program; provides for paid employment over an indefinite period of time, for severely handicapped persons unable to meet production standards required in competitive employment. The wages paid in long term sheltered employment are in excess of 25% of the applicable minimum.
- Work Activity Program: provides for purposeful developmental activity, having a productive or work component for which wages are paid. The level of productivity is less than that required in sheltered employment (generally 25% of the applicable minimum). This program may be transitional in nature or may be considered as an appropriate outcome.

Unless operated by a governmental agency, the long term sheltered employment or work activity program is a legally



federal, state and local statutes. The make-up of the facility's governing body must be in accordance with the requirements of M.S. 121.71 through 121.715 (long term sheltered workshop/work activity law).

When the work activity program is a cooperative effort (M.S. 246.56) between two distinct organizations, there must be a written agreement (i.e. between a sheltered workshop and a DAC or a state institution), which details the responsibilities of each organization concerning staff supervision and training contract negotiations payroll checks, production records, and client supervision and programming.

Comments/Recommendations:

d) Health and Medical Services

Normal health care and medical needs are provided, or we seek to provide, from normal community sources. This is consistent with the principles of normalization, and should be provided to the extent possible, to mentally retarded and developmentally disabled persons. Securing such health services from community sources is encouraged by Department policies and DPW Rule 34.

ICF/MR regulations require the provision of medical and nursing services from within the facility (staff or contract), or by agreement with local persons, hospitals, clinics, that services will be provided as needed.

Retarded persons may have special health and medical needs due to physical disabilities. Such multiple handicaps require higher levels of care and treatment by medical and paramedical professionals. If . such multiple handicapping conditions prevent the person from acting for his own protection in emergencies, he must be placed in a facility that meets institutional provisions of the Life Safety Code, which is required of all facilities housing 16 or more persons. If his condition does not prevent his acting for his own protection in emergencies, he can be placed in a residential facility for less than 16 persons which must meet the residential provision of the Life Safety Code.

The planning and provision of appropriate health and medical services is the responsibility of the CWD, in accordance with DPW policy manual and federal regulations under the Medical Assistance Program, Title XIX, Social Security Act, and specific regulations of ICF/MR.

Comments/Recommendations:

e) Other Community Activities

A variety of community-based experiences should be available to the mentally retarded and developmentally disabled segment of the population. Availability and actual participation in the community will influence the mental health of the individual.

Community activities should include free choice and organized group activities that aid learning to participate as normally as possible. Community organization should consider shopping, eating out, movies, going to church, recreation, ball games, and bowling, as important and sensitive issues in the lives of the mentally retarded and developmentally disabled population.

Comments/Recommendations:

community-based Residential Facilities

a) Planning

Planning of community-based residential facilities (admission, licensing, accreditation, location, determination of need, operational policies, payment, and problem solving) issues overlap the Residential Services Bureau (state institutions). This involves formal and informal relationships of DPW staff (Medical Assistance, Licensing Division, other program divisions, Community Programs Division, guardianship, rate determination), and the Minnesota

Minnesota Epilepsy League, Association of Residences for the Retarded in Minnesota, Minnesota Department of Health, Developmental Disabilities Council, Department of Education, Minnesota Daytime Activity Centers Association, Daytime Activity Centers Advisory Committee, and the Mental Retardation Licensing Advisory Board.

b) Clientele

Approximately 2200 mentally retarded and developmentally disabled persons are served in all types of licensed community-based residential facilities, with a significantly larger population of types B and C in community facilities. At the same time, there is a proportionately larger population of type A in state institutions:

Type A: Mentally retarded persons, including children under age 6, severely handicapped persons, and residents who are aggressive, assaultive or security risks, or who manifest severe hyperactive or psycho tic-like behavior.

Type B: Retarded persons who are moderately retarded requiring habit training.

Type C: Retarded persons who are in vocational training programs and adults who work in sheltered employment situations. Type D: Retarded persons who are living independently or living at home and attending school or who are employed; or otherwise making it on their own but need social services, counseling or financial assistance.

c) Description

Community-based residential facilities serving 2194 persons operate as nonprofit corporate organizations or private proprietary facilities, and must be licensed under M.S. 252.28 (DPW Rule 34), if caring for more than 4 MR/DD persons. Prior to issuance of a program license

be licensed by the Minnesota Department of Health for purposes of health, safety and sanitation (Supervised Living Facility standards became effective January, 1975).

Programs in state operated institutions, serving 3718 persons, are considered in tandem with community-based residential facilities when planning the state-wide capability for mentally retarded/DD persons. Both state and private facilities must meet the same licensing and accreditation standards.

community facilities are eligible for certification as Intermediate

Care Facilities/Mentally Retarded (ICF/MR) providing they meet the various federal and state requirements concerning individualized program planning, types of persons served, staffing, provision of services both in and away from the primary living unit, size of living units, organization and administration of program staff, Life Safety Code, physical condition and mobility of residents, and homelike atmosphere and opportunity.

d) Certification

When certified as ICF/MR, the chargeable rates for such services are determined under the provisions of DPW Rule 52. Rates are required under both licensing and ICF/MR regulations. In May, 197A, payments for care in community-based facilities paid under Title XIX and Cost of Care were made under a plan of central disbursement.

Residents of ICF/MR facilities (and state institutions) are eligible for Supplementary Security Income of \$25.00 per month for clothing and personal allowances. In addition, a special personal allowance

rehabilitation allowance for residents who are employed in a sheltered workshop, activity center, or employed part-time in competitive employment, for which they are paid. This allowance includes work expenses, plus up to \$50.00 additional allowance of Earned income.

Nonprofit residential facilities, including those operated by local units of government, are eligible for grants-in-aid up to 25% of the cost of remodeling or new construction, under provisions of Minnesota Laws 19.73, Chapter 673 and DPW Rule 37. Nonprofit and profit organizations, including local units of government, are eligible for Minnesota Housing and Finance Agency (effective January 1, 1975) guaranteed loans up to 100% of construction costs, over a 40-year loan period for small, home-type residential facilities. Currently, such loans are limited to facilities for 15 or less, housing persons who can act for their own safety, and therefore, must meet the residential provision of the Life Safety Code. (Certificate of self-preservation is required.)

Also, both profit and nonprofit ICF/MR facilities can apply for federally insured loans to upgrade the facility to meet Life Safety regulations (Department of Housing and Urban Development - HUD -P.L. 93-204, as amended by Section 232, National Housing Act).

Planning for persons who are mentally retarded or developmentally disabled, and are in need of any type of social services, is the legal responsibility of the county welfare departments. When placement of a person is indicated in a residential facility, such placement is

responsible for such care, and the resident continues to be a client of that county welfare department. The facility operator then becomes responsible for the development of an individualized program plan for that person which includes specific assessment of health and developmental needs, and the establishment of measurable goals and periodic evaluation. "Facility operators have, a primary responsibility to develop individualized program plans with the county welfare department, parents, relatives or guardian. Community resources that may be available, or made available, must be used according to the individual plan. Priority for such social and developmental services such as recreation, work activity center, daytime activity center, is that they be provided in the community (normalization principle), although mental and physical limitations may preclude for certain individuals that some or all such services and activities be provided within the facility. Residential services to mentally retarded and developmentally disabled persons take place in community-based facilities for 4 or more, ranging in size of up to 130. Primary living units are not to exceed 16 persons under provisions of DPW Rule. 34, although some do at the present time.

Facilities established since 1972 must be located near community resources for social and developmental purposes. Application of the normalization principle requires utilization of community resources for normal types of community activities: recreation.

such experiences, daytime activity centers, sheltered workshops, work activity centers, special education classes, and part-time employment opportunities must be made available to residents of community-based residential facilities.

For these reasons, it is important that determination of need and location of a facility be accomplished with the assistance, advice and cooperation of local planning bodies and service providers. Local groups (county welfare department, area MH-MR staff, professional and parental representatives): have been established and convened through the area boards for such purposes. A more formal structure: for such activities is being developed.

e) Future Needs

The capability of community-based residential facilities must be increased before the population of the state institutions can be decreased. Community facilities must also be able to deliver quality services to retarded persons to prevent their becoming candidates for the state institutions. The Community Alternatives and Institutional Reform (CAIR) project, sponsored by the State Developmental Disabilities Council, will be used as a guideline for Area level and State level planning.

It is important to consider that 89% of the mental retardation and developmental disability population in state institutions fall into type A. This has implications for the type, size and location of future community-based services for the state institutional population, because current capabilities of community-based facilities are addressed more toward type B and C.



Comments/Recommendations:

3. Institution Based Developmental and Residential Services

a) State Institutions, serving 3710 children and adults, operate under the direct control of the Commissioner, DPW, and Assistant Commissioner, Residential Services Bureau. State appropriations for the operation of the institutions are offset by a variety of federal

resources, the principle one of which is Title **XIX**, Medical Assistance, for Intermediate Care Facilities for Mentally Retarded (ICF/MR).

Programs must be licensed under M.S. 252.28 and DPW Rule 34, and by the Minnesota Department of Health Standards for Supervised Living Facilities (effective January 1, 1975), under authority of M.S. 144.50,

State institutions are eligible for certification as ICF/MR providing they meet various federal and state requirements (see Court Order; Welsch vs. Likins) concerning individualized program planning, types of persons served, staffing ratios, provision of services both in and away from the primary living units, size of living units, organization and administration of program staff, Life Safety Code, physical condition and mobility of residents, and homelike atmosphere and opportunity.

When certified as ICF/MR, state institutions earn federal dollar

to the State Treasury, at the rate of 58% cost of care for eligible residents. Practically all retarded residents are eligible for ICF/MR reimbursement. The placing agency (county welfare department) is obligated to pay \$10.00 per month per client in state institutions, while at the same time they are obligated to pay 21.5% of the cost of community-based residential facilities. This provides financial incentive to make placements in the state institutions.

The care level for residents ranges all the way from total life support (such as feeding, clothing, toileting, bathing), on up to developmental training in life skills (such as working, making purchases, and adaptive behavior), so that they are acceptable in a community setting. The major task involves determining the level of independent function to which it is possible to develop the individuals so that the residents can function as independently as possible in the community or state institution.

This includes evaluating the individual's level of functioning, and providing training in life style so that the individual can function in the least restrictive setting, and function in a more independent fashion.

There are 41 Program Units licensed under DPW Rule 34, which are located in state institutions in: Brainerd, Cambridge, Faribault, Fergus Falls, Hastings, St. Peter, Moose Lake, Rochester, Willmar and St. Paul. Each of the facilities serves a designated region of the state.

While DPW attempts to have persons utilize the facility in their region, some residents are placed either at the request of parents (because the parents have moved from one region to another), or, in unusual circumstances, where care and treatment would be more appropriate, in another facility. This placement is closely supervised by DPW, so that the best interests of the person are served.

It is expected that residents in state institution program units receive the necessary training and return to their home or nearby community. Two factors influence utilization of (state institutions:

- 1) the level of care and training is not available in community-based facilities, and
- 2) an appropriate community-based facility does not exist.

State institution programs are a resource to the county welfare departments in carrying out their primary responsibility as agent for the individual in the planning and provision of appropriate services. Counties provide services also to mentally retarded, developmentally disabled, living in their own homes, community based facilities as well as state institution. Many MR/DD persons are able, within their life cycle, to benefit from placement from ' one setting to another.

The historic practice of concentrating retarded persons in state institutions is giving way to providing more services in the community, so that such persons may live in his own home or a community-based facility, where they can get the kinds of

anticipated that the population in state institutions will be significantly reduced in the course of the next few years. The remaining population may be served in fewer facilities, and local administration of them may be more desirable and appropriate in light of community-based responsibility and interest.

b) Program Resources

Volunteer groups and organizations have a long history of services and participation in programs at the institution. These citizens have supplemented institution staff in many varied services that **are important to the residents, but cannot be provided nor**

duplicated by staff, because: of their unique role. Their interest and activity has lead to opening the doors of the institutions to public scrutiny and interest in the dehumanizing conditions that residents exist. Their volunteered assistance is one of the bright lights in the history of state institutions.

Cooperative Vocational Rehabilitation Programs (CVRP), which originate from the Division of Vocational Rehabilitation, provides vocational services which evaluate the resident's vocational potential, and gets them involved and active in various work activity in the institution, sheltered workshops and employment in the community.

Foster Grandparent Program employs eligible persons to provide daily one-to-one relationship for two hours each day to residents. This program is administered by the Minnesota ARC through state appropriations and federal grants.

Special Education Services, now mandatory for residents) under 21 years of age, are provided in the institutions and in community, by the local school districts. This, since 1971, has relieved overburdened staff in institution-directed educational services, to concentrate on the neglected adult population. Such efforts are directed toward the preparation of children and adults for community living.

Title I, Elementary and Secondary Education Act, P.L. 89-313, administered through the Department of Education is significantly reduced from its original few years of service, because the children in the institutions had not, until 1971, been provided with educational services from the local public schools. Since 1971, the number of eligible children for Title I services has been reduced considerably because of the provision of educational services through the public school system. These children are now counted, for eligibility purposes, by the public schools, and therefore, the institutions no longer conduct and operate such programs. Notable among Title I programs that have operated is Project TEACH.

#### c) Communications

Communications between the Director and staff of the Technical Assistance Project (TAP) within the Division of MR/DD, and the chief executive officers of the state institutions and the Assistant Commissioner, Bureau of Residential Services, involves: 1) policies that affect them, 2) problems they experience, 3) assistance in remodeling facilities, 4) interpreting regulations and standards, 5) requests for assistance, and 6) assistance in formulation of policies that will facilitate program goals find

Staff of the Division of Mental Retardation and Developmental Disabilities conduct on site study and evaluation of state institution programs on a scheduled basis, and make official reports to the Assistant Commissioner, Bureau of Residential Services, and the Chief Executive Officers of the institutions. Interim review of policies and plans is done as needed.

Staff of MR/DD Division also take the lead in closing out program units and concurrent development of alternative services.

d) Planning

Planning is basically focused on reducing the institution population and the orderly development of community alternatives.

e) Clientele

Parents and families of retarded persons seek assistance in providing training and care for the retarded person. Often, the needs of the individual retarded/DD person are such that the parents and families are unable to cope with their relative. In attempting to provide for their needs, the families of the retarded persons, currently numbering approximately 3700 persons, turn to community agencies for help and assistance. The agents for the individuals are the 87 county welfare departments, who turn to the state residential facilities for assistance in planning for individual retarded persons for evaluation and assessment and for 24-hour care and training. The county welfare departments also look to the state facilities for assistance in providing in-service training for staff, and for providing in-service training of staff in community facilities who also care for county welfare clients.

For the parents and families, the facilities provide information in the training of the retarded person in their own home. The facilities provide respite care or vacation placement for retarded persons so that the families are able to be relieved of the day-to-day pressures and are able to take a vacation and meet family emergencies when no facilities or services are available at the community level. The major activity is the training and care of retarded persons when the families cannot find the necessary services in the community.

The client is the retarded person in the institution. Services are provided for individuals who have a low functioning intellectual level, who have difficulty in adapting to learning everyday living skills such as eating, dressing, care of personal hygiene, grooming, physical development, receptive and expressive language, interacting

with other people, working for pay, caring for one's clothing/living area, food preparations, making purchases, and whose behavior in addition to the above, or related to the above, makes the person unacceptable in a community setting. In addition, many retarded persons referred to the state institutions have physical and health problems and therefore are in need of habilitative medical care.

The average daily population for fiscal year 1971-72 was 4208; for 1972-73 it was 4004; and for 1973-74, 3750. It is estimated that for fiscal year 1974-75 there will be 3650; for 1975-76, 3575; and for 1976-77, 3500. The decrease in institutionalized retarded will probably continue if the number of persons entering continues to

decrease slowly but releases continue at about the same level as at present. This projection assumes that opportunity for placement in

One of the factors also that will probably influence these estimates is that we have recently begun to see an increase in readmissions to the state institutions of individuals who were placed in the community in recent years.

An unknown factor that could very well influence the estimated figures 'are the new standards established for intermediate care facilities/mentally retarded (ICF/MR). There are an unknown number of retarded persons residing in community group homes that are licensed as board and care facilities, which may not be able to meet the newly defined standards for ICF/MR.

Individuals placed in such board and care facilities that cannot meet the ICF/MR certification standards would be ineligible to receive federal subsidy under Title XIX for the care received. Unless alternate facilities are quickly developed to provide facilities that would meet the ICF/MR standards, or other mechanisms for funding these individuals were developed, we should consider the very real possibility that the average daily resident population at the state institutions during the 1975-77 years might plateau at a somewhat higher level, possibly around 3650. Another factor influencing the development of alternative locations for residential services is determined by the population density of a given county or region of the state.

Continued support of state institutions is needed to provide services because many communities have been unable to provide needed services to the types of residents we have in the institutions. Care and training, and the specialized services that have developed at the



state facilities over the years, are needed because historically, very little was provided to assist parents in the care and training of retarded persons at the community level. The institutions, historically, provide services away from the community, and segregate retarded people from the mainstream of social living. As services develop in the communities through school programs for the educable and later for the trainable retarded, DAC's, etc., parents are assisted in the care of retarded persons. For these reasons we have seen a gradual decline in population in state institutions since 1962.

f) Future Need

Retarded persons will continue to have need for varying levels of supervised living facilities, training and assistance in daily living activities. It is expected that this activity will be shifted to a community network of residential serviced provided at the local area level under jurisdiction and administration of local agencies.

C. The Advocate Function

Customs, laws, public policies and court decisions, uphold the rights of the retarded and other developmentally disabled persons to care, protection, planning services, and the provision of educational, vocational, health, social and self-care training as personally needed. Some examples are:

1. Minnesota Guardianship Laws (and proposed Minnesota Mental Retardation Protection Act, which would replace the guardianship laws)
2. Mandatory Special Education Act, M.S. 120.17
3. Right to Treatment Act, M.S. 1959, Section 253.17, Subd. 9
4. Minnesota Hospitalization and Commitment Act, M.S. 253A.01 to 253A.21
5. Court Order, Welsch vs. Likins, Judge Larson, 1974
6. Patients' Bill of Rights

An advocate represents the rights and interests of the handicapped individual who is unable to do so for himself. Critical to the advocacy function is freedom from conflict of interest. The advocate must be solely concerned with the best interest of the client. Protection is offered to an advocate under the proposed DPW policy on advocacy to assuage fear of recrimination.

Following is a list of exemplative groups and individuals serving as advocates of mentally retarded and developmentally disabled persons:

1. The Minnesota Federation of the Handicapped
2. Epilepsy League
3. United Cerebral Palsy Association
4. The Association for Retarded Citizens
5. Minnesota ARC Advocacy Project
6. Legal Advocacy Project, Legal Aid
7. Consumer Concerns Service (established by the Commissioner as an independent service arm of the system) who identifies, pursues, and meets clientele needs as the client himself views them, distinct from the views of society, professional, or service providers. 8. Citizen advisory groups established in state and service agencies

#### D. The Monitor Function

Monitoring is defined as direct evaluation of a service according to a pre-conceived expectation. This expectation may be a rule, regulation, or an expectation based on defined needs of a handicapped individual. Agency administration, licensing, certification, rate setting and placement are monitoring activities.

The monitoring function sequence is as follows:

1. Information gathering: Accomplished through a visit to a facility,

2. Evaluation: Accomplished by a comparison of information gathered regarding potential services to meet the perceived needs of his child.

3. Response: The response may be issuance of a license or certificate, or placement of a child by a parent or social worker.

Formal monitoring functions are summarized in Figure 2.

Comments/Recommendations:

Rules and regulations which govern the mental retardation plan for residential facilities are part of the monitoring function. They are briefly described below:

1. DPW Rule 34

These Department of Public Welfare (DPW) regulations govern the operation of any individualized developmental program of residential or domiciliary service for more than four mentally retarded individuals. The purpose of the licensing law and these regulations is to implement the Right to Treatment Act and to establish and protect the human rights of mentally retarded persons to a normal living situation through the development and enforcement of minimum requirements for the operation of residential facilities and services. These regulations are promulgated under M.S. 252.28 . which charges the Commissioner of Public Welfare with the responsibility for licensing of residential programs and services for mentally retarded persons, and determining the need and location of such facilities. (In

<u>Service/Function</u>	<u>Information Gathering</u>	<u>Expectation</u>	<u>Response</u>
<b>DAC</b>			
Licensing	Application and site visit	Licensing Rule 3	License
Funding	GIA application	Regional weight	GIA
Vocational Rehab			
Health & Medical			
<b>Residential Services</b>			
Licensing, DPW	Application and site visit, local licensing review	Rule 34	License
SHD, Licensing	Application and site visit	SLP regs	License
Building Code	Submission of blue prints	Uniform Building Code	Permit
Life Safety Code	Submission of blueprints or site visit	LSC	Approval
Rate Setting DPW	Submission of historical costs	Rule 52	Establishment of a rate
CWD	Application to county board	Various	Establishment of a rate
Certification	Application and site visit	ICF/MR	Certification
<b>DPW</b>			
Placement	ARRM Central Referral, site visit, determination of services offered	Individualized Program Plan	Placement Decision

Figure 2. Summary of the Monitoring Function

legend

DPW Department of Public Welfare  
 SHD State Health Department  
 CWD County Welfare Departments

regulations which include ICF/MR facilities - Section 1122 of the Social Security Act.)

## 2. MDH Supervised Living Facilities Standards

A supervised living facility (SLF) is a facility licensed by the Minnesota Department of Health (MDH) in required combination with DPW Rule 34 and/or Rule 80. These regulations establish minimum standards for the construction, equipment, maintenance, and operation of such facilities, in so far as they relate to sanitation and safety of the building; and to the health, treatment, comfort, safety and well-being of the persons accommodated for care, The purpose of an SLF is to provide a non-institutional homelike setting for residential programs for the mentally retarded, the mentally ill, the chemically dependent, and children. These regulations are promulgated under M.S. 144.50 to 144.58, inclusive, Law for Licensing Hospitals and Related Institutions. Consequently, SLF regulations meet federal requirements that ICF/MR facilities comply with the standards of safety and sanitation which are applicable to nursing homes under state law. SLF standards also meet federal requirements under provisions of the National Protection Association's Life Safety Code in two classes:

Class A SLF's include homes for ambulatory and mobile persons who are capable of taking appropriate action for self-preservation under emergency conditions as determined by program licensure provisions. Class A SLF's shall be in conformance with provisions of Chapter 13 of the 1973 Edition of the Uniform Building Code, as amended for Group H occupancies. Physically handicapped persons shall be housed at the street level. DPW Rule 80 establishes the rules of operation for residential facilities and

Class B SLF's include homes for ambulatory, non-ambulatory, mobile or non-mobile persons who are not mentally or physically capable of taking appropriate action for self-preservation under emergency • conditions as determined by program licensure provisions. Class B SLF's shall be in conformance with provisions of Chapter 9 of the 1973 Edition of the Uniform Building Code, as amended for Group D occupancies,

### 3. Uniform Building Code

"The Building Code Division, Minnesota Department of Administration, has adopted the Uniform Building Code (1973) in Minnesota This code as applied to SLF's provides appropriate assurance of life safety from fire for all mentally retarded persons who reside in SLF's.

### 4. Life Safety Code

The Fire Marshal Division, Department of Public Safety., will adopt the Life Safety Code in Minnesota this year. It should be noted that the Life Safety Code is already adopted by reference in the SLF regulations. The significance of this adoption by the Fire Marshal is that the Life Safety Code will incorporate the concepts and language contained in regulations promulgated by DPW, by MDH, and the Building Code Division of the Department of Administration.

### 5. DPW Rule 52

DPW Rule 52 defines a system for the determination of a per diem welfare rate for all ICF/MR facilities with core than four beds participating in the Title XIX program, and is designed to promote efficiency and economy and to treat all providers of ICF/MR care on a uniform basis. This rate setting procedure has been defined to comply with the state statute that requires that cost differences between individual providers

coat limitations to satisfy federal requirements that the welfare rates be consistent with efficiency, economy, and quality of care. These regulations were enacted pursuant to the statutory authority vested in the Commissioner of Public Welfare (M.S. 256B.27) to require reports, Information, and audits, and pursuant to M.S. 256B.04, Subd. 2, to promulgate rules and regulations for carrying put and enforcing, the provisions of M.S. 256B.

Comments/Recommendations:

*Robert H. Brummett*

LEGISLATURE--STATE OF MINNESOTA

LEGISLATIVE AUDIT COMMISSION  
PROGRAM EVALUATION DIVISION

STAFF PAPER:  
THE NEED FOR RESIDENTIAL PLACEMENTS FOR THE  
MENTALLY RETARDED IN MINNESOTA

MARCH 24, 1977



# THE NEED FOR RESIDENTIAL PLACEMENTS FOR THE MENTALLY RETARDED IN MINNESOTA

## INTRODUCTION

This memorandum reports several estimates of the need for community residential placements for the mentally retarded in Minnesota. In assessing need, we have tried to determine that number of beds which could and probably would be used to benefit retarded citizens of the state. We have therefore focused on probable demand for such services, and tried to identify sources of that demand. We have asked ourselves and our informants the following question: "If Minnesota were to provide community residential placements for all retarded persons who could reasonably be expected to use them, how many such beds would be utilized?"

We have consulted several sources in compiling this report: each source's estimate is given below, and includes (1) the number of residential beds considered necessary, (2) the growth necessary to meet this need, and (3) an explanation of how we derived each estimate. Finally, we offer our conclusion as to the best estimate.

This information was compiled and this memorandum written for three reasons. First, through informal contacts we had received widely varying estimates of the need for residential services for the retarded. It seemed logical to investigate these estimates to clarify the situation for ourselves, and to distribute our findings to inform all interested parties of each other's thoughts on the matter. Second, this information is a necessary input to planning. Since planning proceeds on assumptions and predictions of future conditions, widely varying estimates of need can result in very different policies. Comprehensive information and discussion of the factors involved here should be a valuable input to designated Community Mental Health Areas and statewide planning bodies. Finally, information on future needs will be useful as background material elsewhere in this office's study of regulation of human service facilities, especially in evaluating the overall impact of regulation on the care delivery system for mentally retarded persons.

## POTENTIAL USE

An important factor in assessing the number of beds utilizable in the future is the potential use for MR residential services, that is, the number of people who can be expected to come forth and seek services. This potential use process, as it is here called, is exactly the same thing as the process commonly referred to as the "woodwork phenomenon". We have avoided this phrase lest it be construed as insulting to persons now seeking services or MR persons in general.

Potential use refers to the process by which people previously unknown to the care delivery system come to seek services from the system. Persons who come forth via this process are believed to have remained in relative obscurity due to ignorance, or because they believed that the system could not or would not do anything for them even if they attempted to avail themselves of it. Under circumstances of limited services and residential placements for MR persons, such an assumption is probably warranted. Knowledge of the existence of the system dispels ignorance, and knowledge that the system is expanding to accommodate larger numbers of people and diversifying to address a broader range of special needs enhances the confidence of persons previously outside the system to the point that they now seek services from it. Undiagnosed and diagnosed MR persons now residing in nursing homes or other facilities constitute another source of MR persons who would seek services from an expanded delivery system.

## THE ESTIMATES

### A. THE ESTIMATE OF THE MINNESOTA HOUSE APPROPRIATIONS COMMITTEE

The House Appropriations Committee of the Minnesota State Legislature draws on information from the President's Committee on Mental Retardation for its premises and methodology. The President's Committee posits that 3% of the population is retarded, but that only 1% of the population is severely enough retarded to require services. Of these, only one-fifth require residential placement and services. Applied to the approximately 4,000,000 citizens of Minnesota, these percentages

yield 120,000 retarded, 40,000 requiring services and 8,000 requiring residential care and services. According to the Appropriations Committee's sources, as of April, 1976, there were 6,016 MR persons in state hospitals and community facilities and another 667 persons in nursing homes (Skilled Nursing Facilities and general Intermediate Care Facilities).

Assuming that the MR population in state hospitals will remain constant, the current data indicate that there is a need for 1,984 more community MR beds ( $3,000 - 6,016 = 1,984$ ). The existing stock of MR beds will have to be expanded by 32.98% ( $1,984 / 6,016 = .3298$ ) to meet this need. These figures are shown in Table 1. One potential source of these beds might be conversion of SNF and ICF beds to ICF-MR beds, although this might prove to be a problem because the nursing homes are generally large and not readily adaptable to the programming and environmental needs of MR persons. The data suggest that there will be some 1,317 new persons ( $8,000 - 6,016 - 667 = 1,317$ ) seeking services from the system.

Alternatively, assuming that the state hospital MR population will decline to 3,000 by 1980 and to a constant (equilibrium) level of 1,800 in the long run, required growth would be 2,359 new community beds by 1980 and 3,559 in the longer period.

#### B. THE ESTIMATE OF THE DEPARTMENT OF PUBLIC WELFARE MENTAL RETARDATION PROGRAM DIVISION

Mr. Ardo Wrobel, Director of the DPW Division of Retardation Services, believes that by 1980 there should be 7,000 to 7,500 MR beds in the state. His estimate is obtained as follows: There are approximately 3,375 MR persons in the state hospitals, and about 3,000 more persons in community facilities for the retarded. There is a "waiting list" for placement in community residential facilities of 601 persons, of whom an estimated 50% are in state hospitals. Adding 300 (the 50% of those on the waiting list who are not currently in residential facilities) to the previous figure gives 6,675 MR persons, and an allowance for 325 to 825 people latently coming forth to seek services makes up the balance of this estimate. This indicates that the number of people seeking placement will increase by between 4.9% ( $325 / 6,675 = .049$ )

and 12.4%. Correspondingly, the total number of beds will have to increase from the present 6,375 by 9.8% ( $625 / 6,375 \times 100$ ) to 17.6%. Mr. Wrobel believes that the potential use process has definitely slowed recently, and that this is an indication that it is nearing the end of its course.

In reaching this estimate, Mr. Wrobel considered several factors. He wanted to be conservative and to avoid overbuilding of facilities and system capacity. Since current expansion is aimed primarily at the ambulatory, relatively uncomplicated mainstream of the MR population, he is specifically concerned that the community care delivery system will overdevelop its capacity to serve this group while ignoring groups with special needs.

Further, there is the potential problem that a large expansion of beds in the short run will result in excess capacity later. The system is intended to offer a continuum of levels of care and to move people within it as far toward normal living as possible. If the system works well, then, a significant number of MR persons will move through and out of the supervised residential service stage of the system into independent living situations. There is no guarantee that there will be persons waiting to move into the vacated places on a continuous basis. Thus, it is possible that beds will lie empty. This problem is compounded by the possibility that facility operators may try to retain residents, however inappropriately, in order to keep themselves in business. These two considerations further mandate that care be taken to avoid over-development of residential facilities.

Mr. Wrobel feels that the most appropriate course to follow is to allow development to about 7,500 total beds by 1980 and to exercise rigorous control in permitting development beyond that, to assure that gross excess capacity is not developed for any group of the MR population. An incorrect decision leading to a shortfall in construction of beds would be less costly and more easily rectified than one leading to significant over-construction.

To fulfill its responsibility of sound planning, the Department is in the process of promulgating Rule 185 relating to assessment of local need and planning for the development of facilities on a local basis. The Department now has the authority to approve or reject applications to operate MR facilities according to the overall needs of the system and the MR population; Rule 185 is intended to be the strong, clear rule necessary to back up the exercise of this discretionary

authority. Successful implementation of this rule will depend on the efforts of the Area Boards. .

Mr. Wrobel further believes that by the time the system has developed to a capacity of 7,000 beds, a rigorous process of review of applications to operate facilities must be established. As one element of that process, he advocates that applicants should be required to specifically identify approximately 75% of their intended clientele. This is determinable and obtainable from Area Board Need Assessment and Plan documents, County Welfare Departments, and the waiting lists of existing facilities. The unidentified remainder of the facility's capacity would allow for people coming forth via the potential use process. This specific identification procedure in the need determination process will guard against overbuilding and also against arbitrary placement of persons.

A very important consideration is the distribution of total MR beds between state hospitals and community based facilities. Mr. Wrobel estimates that there are roughly 1,800 persons who require the intensive and comprehensive care available only at very large institutions (i.e., state hospitals). Placing the rest in community facilities will require 2,200 to 2,700 new beds in community facilities in addition to the 3,000 currently licensed. (As of May, 1976, there were 1,991 beds licensed under DPW Rule 34 and funded by Cost of Care Grants for MR children, a total of 2,389 beds. The most recent update from the Technical Assistance Project staff showed 2,999 licensed community facility beds in the state.)

Mr. Wrobel believes that the state should aim to achieve a total capacity slightly greater than (approximately 102% of) total need. Such a situation would enable the state and counties to put competitive pressure on all providers to upgrade quality, lest they lose referrals and thus be forced out of business. The idea here is to use the fact of slight excess capacity to provide an incentive to facility operators to deliver higher quality services in order to obtain and keep (revenue producing) residents.

To recapitulate, Mr. Wrobel does not disagree with the Program Evaluation Division's estimate, developed in G below, of 9,000 beds as total need for MR residential placements. He is uncertain whether it will be that great, but readily acknowledges that it may be. His argument is that the system should aim to develop to 7,500 total beds over the next four years, with development beyond that subject to rigorous scrutiny of the needs of the system and of the served

population at that time. The key issues, as he sees them, are the course which the development of the system will take and the roles which responsible parties will play in directing that development.

Kathryn Roberts of the DPW Division of Retardation Services is presently reviewing the Community Mental Health Area Boards assessments of need for MR residential services. Unfortunately, the data received from the Area Boards thus far are unreliable. Ms. Roberts generally agrees with the figure of 8,000 beds reported in A above as an accurate estimate of required capacity for MR residential services.

Ms. Roberts voiced two concerns which are important here. The first is that indiscriminate development of facilities will have undesirable impacts in that residents will be inappropriately placed in them. She is concerned that once residential placements are created, persons will be found to occupy them, even if their characteristics and needs are not appropriate to the facility in which they are placed. This is likely to affect higher functioning MR persons, including those coming forth via the potential use process, more seriously than other groups. For example, persons who would most appropriately be placed in apartment training programs or living entirely independently may be placed in group homes by social workers or coaxed into them by providers. Social workers and providers are likely to proceed on the premise that since there are beds, there must be persons to fill them. This underscores the need for sound planning by responsible parties.

Her second concern is over the absence of a monitoring mechanism to assure that persons in the system continue to progress through the continuum of care until they attain their highest level. Ms. Roberts is concerned that providers hold attitudes which are contrary to resident progress in accordance with the normalization principle, and that there is nothing in the present regulatory structure to assure that the spirit of that principle is observed.

### C. THE ESTIMATE OF THE METRO COUNCIL

The Metro Council derived its estimate via the following reasoning. Three percent of the general population

is mentally retarded. One-third of this three percent will need residential placement. The estimated population of the Metropolitan Area for 1975 is 1,927,600. One percent of this yields the estimate of 19,276 persons needing residential services in the Metropolitan Area in 1975. Doubling this, which is standard procedure when extending population data for the Twin Cities to the entire state, yields an estimated need of 38,552 beds. Given the 6,375 beds presently in service in the state, and assuming that the census of state hospitals will remain constant, the apparent necessary growth is 504.7%, or 32,177 new community beds. If the state hospital population were to fall to 3,000 by 1980 and to 1,800 as a stable level in the long run, required growth would be 32,552 new community beds by 1980 and 33,752 in the longer period.

In fairness, it should be pointed out that the Metro Council did not make this extension, inasmuch as they are concerned only with the needs of the Metropolitan Area. We made the extension to show the implications of their estimate for the state. Furthermore, a straight doubling of the estimate for the Metro Area probably yields a high estimate for the state because the Metro Area tends to have a higher concentration of retarded persons, owing to the concentration of major treatment centers there.

#### D, THE ESTIMATE OF THE ST. PAUL ASSOCIATION FOR RETARDED CITIZENS

Mr. Bob Tuttle, Director of the St. Paul Association for Retarded Citizens (SPARC) agrees with the Program Evaluation Division's methodology in deriving the estimate given in F below. An advocate of community based residential services for the retarded, Mr. Tuttle says that 10,000 beds is the absolute maximum need for Minnesota. (This top end estimate from an MR advocate is a strong indication that the Metro Council's estimate is too high.)

Important consideration must be given to the types of residential services provided and to the proper mix of services to best serve the MR population. Special needs cited by Mr. Tuttle are for mentally retarded, mentally ill teenagers and for physically handicapped, multiply involved children. These persons are presently inappropriately situated, either at home, in foster homes, or in child caring institutions. For this latter group, approximately 320 beds would

be needed in the Twin Cities, and an additional 215 out state. There is also a need to identify and relocate MR persons in nursing homes who are as yet undiagnosed. Though special needs groups are mentioned here, the overall point is that careful consideration must be given to the range of types of care required to serve the MR population appropriately.

#### E. THE REGION TEN DEVELOPMENTAL DISABILITIES COUNCIL

Douglas H. Butler, Developmental Disabilities Program Manager for the Southeastern Minnesota Regional Development Commission, reports that the Region Ten Developmental Disabilities Council has estimated a range of 674 to 1,265 residential placements necessary to meet the needs of mentally retarded persons in the region. The minimum of the range was obtained from a 1974 regional survey of residential facilities. The survey data imply a minimum need of 1.76 beds per 1,000 population ( $674 / 383,369 = .00176$ ). The maximum was obtained by applying the estimation formula used by the National Association for Retarded Citizens: three percent of the general population is retarded, and eleven percent of the MR population may be moderately to profoundly retarded persons who could benefit significantly from residential care. This yields a range maximum of 1,265 placements (beds) when applied to the region's 1970 population of 383,369 and implies a maximum need of 3.3 beds per 1,000 population.

Applying the above coefficients to Minnesota's population of 4,000,000 yields an estimated range of 7,040 to 13,200 placements needed for the state. Mr. Butler goes on to agree with the range of 8,344 to 10,013 beds estimated in section F following and with the "best estimate" of 9,000 beds set forth in G below.

Mr. Butler voiced strong concern that the limits to residential service development should be determined via a process of regional project review. Citing Region Ten's cooperative effort at comprehensive developmental disabilities planning by the Southeastern Minnesota Health Systems Agency and the Region Ten Developmental Disabilities Council as a prototype for such a review process, he stated that it would be a mistake to supersede regional planning and review and to legislate a limit on the number of MR residential placements to be developed in Minnesota. He concurred with the positions stated



elsewhere in this paper that there must be a sound process for "determining the geographic and care type distribution of beds throughout the state. He would have this process based on regional and area planning and review. The following arguments for regional responsibility for residential service, planning and development come from The Future of Southeastern Minnesota Update; Residential Service Design and Development Plan for People Who Are Developmentally Disabled:

1. Decisions would be made in relation to an existing plan. Currently, they are made on an ad hoc basis, with no framework.
2. Decisions would be made by people close to the need, who know the local situation and who are committed to improved conditions.
3. Monitoring the establishment of facilities would take place at a decentralized level.
4. Decision making closer to the community which needs services facilitates a(n)... efficient, informed response from the decision makers."<sup>1</sup>

#### F. A SYNTHETIC ESTIMATE

This estimate uses information from Dennis Bogen, MR Program Coordinator at Fergus Falls State Hospital, the Department of Public Welfare, and internally generated assumptions. Mr. Bogen, via contacts with county social workers

<sup>1</sup> Southeastern Minnesota Regional Development Commission, The Future of Southeastern Minnesota Update: Residential Service Design and Development Plan for People Who Are Developmentally Disabled, September, 1976, p. 58.

and welfare departments in the area served by Fergus Falls State Hospital, has a solid estimate of 3,000 known MR persons who have required services of 'some kind in that area. There are approximately 300 MR persons in the hospital. This indicates that approximately 10% of the known MR are in state hospitals. Roughly another 10% are in community facilities. This brings us, coincidentally to the 20% figure cited by the President's Committee on Retardation.

Now, if approximately 20% of the known MR are in residential facilities, then the number of MR persons requiring services of any type is five times the number in facilities. That is,  $\text{Number in Facilities} = .2 \times \text{Number Requiring Services}$ , or  $\text{Number Requiring Services} = \text{Number in Facilities} \times 5$ . The DPW estimate of residential placements as of May, 1976, is 6,375 persons. Adding the 300 who are awaiting residential placement to this latter figure yields 33,375 persons ( $6,675 \times 5$ ) needing services of any sort, or 33,375 MR known to the care delivery system.

Next we consider some alternative assumptions of growth in potential use of residential services. If we allow that half again the number (50%) presently in facilities or awaiting residential placement will come forth as services become more readily available and residential placements more easily attainable, we arrive at an estimate of need of 10,013 beds ( $6,675 \times 1.5$ ). Alternatively, assuming total growth of only 25% of the number currently in facilities or awaiting . placement, we estimate a total need of 8,344 beds ( $6,675 \times 1.25$ ),

If the state hospital MR population falls to 3,000 by 1980, the range of need for new community residential placements would be increased to 2,344 to 4,013 beds. If the state hospital MR population fell to 1,800, the need for new community placements would range from 3,544 to 5,213 beds.

#### G, FURTHER **CONSIDERATIONS:** A REFINED "BEST" ESTIMATE

##### Potential User Limiting Factors

There are several factors affecting the number of people expected to come forth from the potential use group

and seek placement in residential facilities. We believe that these factors will operate to raise significantly the estimate of the President's Committee on Retardation. Operating to limit the number still to come forth is the fact that Minnesota, relative to the rest of the U.S., has gone further with its commitment to comprehensive care for the MR and has better developed funding and administrative institutions through which to fulfill its commitment. Medical assistance (via Title XIX of the Social Security Act) pays for adults and eligible children in ICF-MR facilities and state Cost of Care Grants pay for MR children who are not eligible for aid via Title XIX funds. The point to be made here is that it is relatively easy for MR persons to receive care in Minnesota; given this relative ease, it could be expected that most persons requiring care will already have come forth to seek it.

#### Potential Use: Expanding Factors

Three main factors operate to expand the number of MR persons who will seek residential services: First, there are very probably a significant number of undiagnosed and/or inappropriately placed MR persons in nursing homes, foster homes and child caring institutions who will be identified as the overall MR care delivery system is expanded.

Second, there are unidentified persons either living at home with parents or living marginally or sub marginally in society who can benefit from placement in a community residential facility. The absence of placements and services and ignorance of opportunities for such services will have limited those seeking them in the past. Further dissemination of information and seeking out of those who could benefit from residential services by public and private medical and social agents will expand the number of MR seeking residential care.

Finally, there are some MR who will seek temporary placement in residential facilities. These are generally known as "respite care" residents or clients. The time period involved with this category can vary from one week up to six months. There are two classes of respite care: The first is care intended to give the parents or caretakers of persons living at home a break from the intensive effort they must put forth for their MR children, or to provide parents with free time necessary to manage an emergency in the household.

The second type is residential placement for specific, short-term training. On balance, we believe that these expansionary factors will outweigh those tending to limit the number of persons seeking residential services.

## Respite Care

Current opinion has it that maintaining an inventory of beds for respite care is prohibitively expensive. It seems, however, that with proper management, residential care for MR persons on a short-term, respite care basis should not prove much more expensive than long-term residential care. Specific training should be less expensive than comprehensive programming, and for very brief stays, programming costs should be minimal. Furthermore, proper management can promote optimal scheduling of resident stays for specific training and for normal parent relief, with only a small open stock of beds necessary for emergencies. This should tend to minimize vacancies and thus to maximize utilization, thereby tending to keep costs at a reasonable level. At the least, the question merits further investigation before the prospect of an adequate respite care system is dismissed.

A hypothetical model for determining the need for respite care placements follows. The assumptions used here would seem to be fairly realistic, but we have no factual basis either for the percentage of MR persons requiring respite care or for the percentage of respite care beds necessary to accommodate emergency situations.

1. Of the 40,000 Minnesotans requiring retardation services of any kind, 8,000 require continuous residential facility care. This leaves a balance of 32,000 persons who might utilize temporary placement to significant benefit.
2. Assume that half (50%) of these will require (or be able to utilize for significant benefit) two weeks of respite care residential placement per year. This means that  $32,000 \times 5 \times 2 = 32,000$  resident-weeks of respite care residential services would be utilized if provided.

Since one bed/placement can provide 52 resident-weeks per year, dividing the number of resident-weeks required by 52 will yield the number of beds necessary. In this case,  $32,000 / 52 = 615.38$  beds, or 615 beds.

An allowance of ten percent of these beds for respite care to accommodate household emergencies implies that some 62 of these beds should be held in reserve for such emergencies. Thus, the balance of 553 beds should be available for scheduled parent/guardian relief and special training care.

#### A Refined "Best" Estimate

With all of the preceding factors considered, we would offer the figure of 9,000 beds as a "best estimate" of the number of MR beds which could be utilized for significant benefit by 1980. The formula implicit here is that of the one percent of the total population requiring mental retardation services, 22.5% (versus the 20% coefficient used by the President's Committee on Retardation) can utilize residential services for significant benefit ( $4,000,000 \times .01 \times .225 = 9,000$ ). We feel that this estimate takes account of a full progression of potential use. Significantly, it lies exactly between the estimate of the President's Committee and the top end estimate of an advocate for the retarded. The implicit growth in this case, assuming a constant MR population in the state hospitals, is 41.2% - in the number of beds and an expected growth of 34.8% in the number of MR persons seeking residential care. We also believe that this figure takes fair account of the slight natural increase in need for MR services which will derive from population increases in the next four years.

Alternatively, assuming that the state hospital MR population will decline to 3,000 by 1980 and to a constant (equilibrium) level of 1,800 in the long run, required growth would be 3,000 new community beds by 1980 and 4,200 new community beds by the time the state hospital MR population is stabilized. The rate of deinstitutionalization over the longer period will depend on the rate at which new community beds become available.

Again using input from Bob Tuttle of SPARC, we would say that, geographically, approximately 60% of these 9,000 beds should be located in the Metropolitan Twin Cities area. This is because people and families with severe MR problems have tended to gravitate toward the Cities in the past, since major treatment centers are located there. We take this position based on the established situation; we would not advocate location of facilities in any region disproportionate to that region's need.

#### H. THE REGION NINE DEVELOPMENTAL DISABILITIES COUNCIL

Carol M. Boese, planner for the Developmental Disabilities Council of the Region Nine Development Commission, reports that a 1975 survey by her office concluded with an estimate of 465 beds necessary to meet the needs of Region Nine's mentally retarded persons. County welfare departments in the region were asked to list facilities serving their clients. Facility operators were then requested to complete a survey form for each resident. The data thus generated were studied to determine the number of persons requiring different levels and types of services. The estimate (of 465 beds) thus obtained was virtually identical to that obtained by applying the formula of the President's Committee on Retardation (see A above) to Region Nine's population (464 placements, versus the 465 estimated by the Region Nine survey). While these estimates are strikingly similar, Ms. Boese goes on to argue that the survey estimate (and therefore the PCR estimate) is low versus the region's actual need, for the following reasons:

1. Only legal residents of Region Nine were surveyed.
2. The survey population was, by design, composed mainly of adults. The school-age population was therefore largely omitted from the survey, and thus the survey failed to identify a significant number of persons needing services.
3. Only those currently being served were surveyed. Those who could well use services but who were not currently being served were omitted.

Ms. Boese believes that Mr. Wrobel's estimate in B above is a bit low and that the range maxima in D, E and F are a bit high. She believes that the "best estimate" from G is the most feasible when applied to Region Nine, agreeing that the regional estimate derived therefore of 522 beds is a "legitimate conservative estimate".

There are various factors which must be considered in making these predictions, including:

1. the stabilization of Minnesota's population;
2. the potential use process; and
3. the rate of deinstitutionalization of present state hospital residents until a fairly constant population is reached. Both the long run level of this population and the rate at which deinstitutionalization proceeds are important.

Further, the following potential program efforts would likely affect the need for residential services:

1. early identification of problems to get children to needed resources sooner: This might increase utilization of residential services in the short run and decrease long run utilization as residents become better adjusted to independent living.
2. early stimulation programs to encourage fullest development of potential: This implies an increase in such programs in both the short and long run, probably leading to decreased need for certain types of residential services in the long run as participants in these stimulation programs are promoted to more independent living situations.
3. education of the general public designed to help them decrease the causative factors of retardation.

Finally, Ms. Boese is concerned that services should be distributed proportionately throughout the state, according to need in the various regions. Satellite centers and other major treatment facilities have served as drawing centers in the regions. Her point is that decentralization of services is the most appropriate policy: further centralization of facilities, causing MR persons and their families to relocate to obtain services, should be avoided wherever possible.

## SUMMARY

Table 1 summarizes the estimates of different projections of total need for residential placements and percentages by which the existing stock of beds will have to grow in order to meet this need. It must be noted that only Ardo Wrobel of DPW gives an estimate of the required distribution of beds between state hospitals and community residential facilities. This is a question which must be addressed by further study.

All of the estimates except that of the Metro Council are in the range of 7,000 to barely over 10,000 beds.

Special attention must be paid to the needs of the various care groups within the overall MR population. This does not mean that priority should be assigned to "special needs" groups, but that there are numerous groups with different care needs and that these differences must be considered in planning the mix of programs and facilities for the MR in Minnesota. Further study along these lines is warranted. Furthermore, future study will have to take account of different conditions of need and system capacity in specific geographic regions of the state.

## CONCLUSIONS AND RECOMMENDATIONS

We conclude that 9,000 beds could be utilized to significant benefit by mentally retarded persons in Minnesota by 19 00. We believe that this takes fair account of natural growth due to population increase, expansion of the number seeking services via the potential use phenomenon and relocation of those now inappropriately placed.



The analysis in this report generally proceeds on the assumption that the types of services offered will not change significantly in the foreseeable future. This has two major implications for the conclusions reported here:

1. Expansion of residential services will require some proportionate expansion of support services, especially day activity centers/services.<sup>2</sup>
2. If support services such as respite care, companionship services and parent/guardian counseling for persons living independently or with their families were expanded significantly, the need for residential placements would be less than it would be otherwise. Furthermore, such services combined with relatively independent living situations may well prove to be the "least restrictive", most normal alternative for MR persons. The implications of this discussion are (a) that a greater quantity of respite care placements and other support services would be utilized to significant benefit, if provided, than this analysis would otherwise indicate, and (b) that a lesser amount of regular residential placements would be utilized.<sup>3</sup>

These factors must be considered in the planning and development of Minnesota's MR care system.

Special attention must be paid to conditions of need and system capacity both for specific needs subgroups of the total MR population and also for specific geographic areas

<sup>2</sup> we are indebted for this point to Flo Hauber, formerly of the Division of Vocational Rehabilitation of the Department of Education, now affiliated with Special Education Programs at the University of Minnesota.

<sup>3</sup> This important and insightful contribution came from Marylee Fithian, Director of the Developmental Disabilities Planning Office of the State Planning Agency.

The attitude that all applications to operate MR facilities must be approved will have to be replaced with more specific planning goals and policies as specific geographic and care type niches in the delivery system become filled. The variation in observed regional population growth rates highlights this point. Between 1970 and 1975, these rates varied from -1% for Region 6W to +18.3% for Region 7E. Also, with the current emphasis on expansion for special needs groups, it is likely that program capacity for persons with certain special needs will be reached relatively soon. Planners must heed these factors in setting priorities for further development of the system. In some cases, they must begin to set priorities and to promote actively the development of residential services in areas not adequately served under the present regime of general, permissive policies.

This need for specific planning cannot be stressed strongly enough. The consequences of failure to meet it are not only the potential waste and inefficiency of surplus beds, but also the injustice of inappropriate placement of MR persons. Responsible parties the County Welfare Departments and their social workers, the Area Boards, providers, and the Department of Public Welfare must act to assure sound planning and the appropriate, organized development of the care system for mentally retarded persons.

On general principle, we would advocate that no prospective provider be prevented from opening a facility even if present needs were being met. As Ardo Wrobel noted, slight excess capacity can have desirable competitive effects. Short of vetoing proposed facilities, regional and area planning bodies could diminish or cease recruitment efforts once needs were being met and could advise prospective facility operators that the potential market for their services was unfavorable. DPW could decline to provide grants to new facilities in areas where needs were being met unless they wanted to encourage the competitive effects mentioned earlier.

Finally, the experiences which led us to undertake this project lead us now to suggest better communications among relevant and interested parties to promote better coordination of the developing MR care system.

TABLE 1. ESTIMATES OF NEEDED MR BEDS IN MINNESOTA

ESTIMATOR	ESTIMATE OF TOTAL BEDS NEEDED	REQUIRED GROWTH (NEW BEDS) <sup>1</sup>	REQUIRED GROWTH (%) <sup>2</sup>	REQUIRED GROWTH (NEW BEDS) <sup>3</sup>	REQUIRED GROWTH (NEW BEDS) <sup>4</sup>
A. House Appropriations Committee May, 1976	8,000	1,984 <sup>5</sup>	32.98 <sup>5</sup>	2,359 <sup>5</sup>	3,559 <sup>5</sup>
B. Ardo Wrobel, DPM June, 1976	7,000 to 7,500	625 to 1,125	9.80 to 17.65	1,000 to 1,500	2,200 to 2,700
C. Metro Council September, 1976	38,552 (19,276 in Metro Area)	32,177	504.74	32,552	33,752
D. Bob Tuttle, SPARC November, 1976	not more than 10,000	≤ 3,625	≤ 56.86	≤ 4,000	≤ 5,200
E. Region 10 Development Disabilities Council	7,040 to 13,200	665 to 6,825	10.43 to 107.06	1,040 to 7,200	2,240 to 8,400
F. Bogen, Burt, Wright Synthesis November, 1976	8,344 to 10,013	1,969 to 3,638	30.89 to 57.07	2,344 to 4,013	3,544 to 5,213
G. Best Estimates	9,000	2,625	41.18	3,000	4,200

<sup>1</sup> The base number for this calculation is 6,375 beds - 3,375 MR beds in state hospitals and 3,000 beds in community facilities. The figures given in this column are for estimated needed growth in total beds \* the amount of each estimate less 6,375.

<sup>2</sup> The required growth in percentage terms is given by the formula:

Required Growth (Reds) »  $\frac{\text{Required Growth (Beds)}}{\text{Current Beds}}$

6,375

<sup>3</sup> The figures given in this column are for estimated needed growth in new community beds by 1980 assuming that the state hospital MR population will fall to 3,000 by that time. Therefore, these numbers are the difference between the estimate of total beds needed and 6,000 (3,000 hospital beds plus 3,000 presently existing community beds).

<sup>4</sup> The figures in this column are for estimated needed growth in new community beds by the time the state hospital MR population stabilizes at 1,800 beds. Thus, the numbers are the difference between the estimate of total beds needed and 4,800 (1,800 state hospital beds plus 3,000 presently existing community beds).

<sup>5</sup> These figures are different than those expected according to footnotes 1 through 4 because they utilize a base of 2,641 existing community beds (6,016 - 3,375 = 2,641). For example, in the fourth column, 2,359 beds is the difference between 8,000 and 3,000 state hospital beds plus 2,641 community beds (8,000 - 3,000 - 2,641 = 2,359). The difference between 2,641 community beds used here and the 3,000 beds used elsewhere is probably attributable to earlier data collection.

DPW REGULATORY FUNCTIONS .....	Marshall R. Whitlock Jo A. Vos
DOC REGULATORY FUNCTIONS .....	Jo A. Vos
THE IMPACT OF REGULATION .....	Sharon Studer
COSTS OF REGULATORY AND CONTROL ACTIVITIES OF THE MINNESOTA DEPARTMENT OF HEALTH.....	Scheffel Wright
COST OF REGULATORY AND CONTROL ACTIVITIES OF THE DEPARTMENT OF PUBLIC WELFARE....	Scheffel Wright
COST OF COMPLIANCE WITH REGULATIONS INCURRED BY FACILITIES FOR THE MENTALLY RETARDED AND THE MENTALLY ILL.....	Scheffel Wright
AMOUNT AND COST OF SERVICES DELIVERED IN FACILITIES SERVING THE MENTALLY RETARDED AND THE MENTALLY ILL .....	Scheffel Wright
INCENTIVES .....	Scheffel Wright
THE NEED FOR RESIDENTIAL PLACEMENTS FOR THE MENTALLY RETARDED IN MINNESOTA....	Scheffel Wright
REGULATION AND CONTROL OF HUMAN SERVICE FACILITIES: FINAL REPORT .....	Martha Burt